Title: Are talking therapies culturally relevant for the British South-Asian community?: a look into the views and experiences of British South-Ssians

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Are Talking Therapies Culturally Relevant for the British South-Asian Community?: A Look into the Views and Experiences of British South-Asians

by

Sidhra Adilia Khalil

A thesis submitted to the University of Bedfordshire, in fulfilment of the requirements for the degree of Master of Science by Research

University of Bedfordshire

Research Centre for Applied Psychology

November 2018

Declaration of Authorship

I, Sidhra Adilia Khalil, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

Are talking therapies culturally relevant for the British South-Asian community?: A look into the views and experiences of British South-Asians

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Are Talking Therapies Culturally Relevant for the British South-Asian Community?: A Look into the Views and Experiences of British South-Asians

Abstract

The personal experiences of South-Asians who have accessed talking therapy have been widely overlooked in the development of culturally adapted therapies for ethnic minorities in the United Kingdom (Naeem et al., 2015). This research aimed to gain an understanding into the experiences of British South-Asian service users, discovering the views held towards existing mental health services and exploring how their experiences shaped these. Additionally, the experiences of community members and professionals were also explored, with all three groups being sought to discover whether talking therapies were culturally relevant for the British South Asian community in England. This qualitative study consisted of 20 semi-structured interviews carried out with British South-Asian service users (n=4), British South-Asian community members (n=5) and mental health professionals (n=11) who had experience of providing therapy to the South-Asian community. Interviews were analysed using inductive thematic analysis, with four key themes arising within each group. There was consensus among the three groups that specific barriers caused difficulty when accessing services, including cultural norms and perceptions towards mental health, English as a second language and limited cultural understanding within existing services. Findings are discussed in relation to previous research into minority communities and recommendations for future research are made.

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Table of Contents

List of Tables

Chapter 2

Glossary of abbreviations:

Below is a list of definitions for all abbreviations used within this research:

Black and minority ethnic (BME)

Cognitive behavioural therapy (CBT)

General practitioner (GP)

Mental health issues (MHI)

Mental health professional (MHP)

Mental health services (MHS)

National Health Service (NHS)

South Asian service user (SASU)

South Asian community member (SACM)

Non-South-Asian mental health professional (NSA-MHP)

South-Asian mental health professional (SA-MHP)

United Kingdom (UK)

Chapter 1. Introduction

This chapter will focus on introducing relevant existing literature relating to the area of culturally relevant mental health services and talking therapies for ethnic minority groups, with a focus on the South Asian community in the United Kingdom. Alongside the literature review, gaps within current research will be identified. The rationale for the need for research in the field of exploring the experiences of those who access mental health services will also be discussed.

1.1 Literature Review

Mental health refers to *'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'* (World Health Organisation, 2014). Approximately one in four adults in England are affected by mental health issues (MHIs) each year, with four to ten percent of individuals experiencing depression throughout their lives and mixed anxiety and depression occurring most commonly (McManus et al., 2009). MHIs are typically treated by using either a biomedical or a psychosocial approach. The biomedical approach is commonly taken within primary care (such as general practice surgeries) and seeks to understand the neurological factors to explain mental illness, treating conditions through medication. Alternatively, the psychosocial approach attempts to combine individual and environmental strengths to improve and develop effective personal and interpersonal functioning through psychological talking therapies (Skeen et al., 2010). Talking therapy can be defined as a service in which a relationship is established between a professional and a client, aimed at alleviating distress or improving the mental state of the client, through establishing an environment in which

confidential and non-judgemental communication can take place (Hough, 2010). Statutory mental health provisions are made within the National Health Service (NHS) and psychological therapies can be accessed via self-referral or through a general practitioner (GP) (Fernando, 2005; NHS, 2016).

Despite the existence of mental health services (MHS), it is estimated that 75 percent of the affected population do not access help (Mental Health Foundation, 2015; NICE, 2011). It is common for individuals to refrain from seeking help if they hold the belief that issues will disappear given time (Sareen et al., 2007) and that they can be dealt with without the influence of an outsider (Wilson & Deane, 2012). It has previously been reported that a lack of recognition towards symptoms of mental illness and a lack of awareness of existing MHS can also result in under-utilisation, especially if individuals are prescribed psychotropic medication as their only form of treatment when accessing a GP for a MHI (Smith, 2012; Memon et al., 2016). On occasions where referrals are made, waiting lists hinder timely access and can lead to individuals holding negative beliefs towards services and refusing to access help (Czyz et al., 2013; Williams, Latta & Conversano, 2008).

Where mental health services had been accessed, they were found to be inappropriate for the cultural needs of Black and minority ethnic (BME) communities due to cultural and institutional exclusion (Bowl, 2007). These limitations within services were observed by McLean et al. (2003) , characterising cultural exclusion as the inability of MHS to provide appropriate understanding for service users who did not belong to the White majority population, and institutional exclusion as the inability for organisations to acknowledge specific needs and differences, such as those related to ethnicity. Therefore, some of the common difficulties that may result in under-utilisation of MHS are stigma

(Corrigan, 2004), socio-economic exclusion (Matthews, Corrigan, Smith & Rutherford, 2003), and cultural beliefs held towards causes and treatment of mental distress (Anand & Cochrane, 2005).

One of the groups that has been found to have poor experiences of MHS in the UK is the British South-Asian community. Members of this group tend to originate from countries such as Afghanistan, Pakistan, India, Bangladesh, Nepal, Bhutan, Sri Lanka and the Maldives (Williams, Stamatakis, Chandola & Hamer, 2011). Inhabitants of this region traditionally have a deep attachment to distinctive religious beliefs and practices, with many living their lives according to these teachings. Religion can be understood as a "way of life" for adherents, with teachings and Holy Scriptures offering a moral purpose, guidance, and strength and healing in times of difficulty (Horden, 2016). The two most common belief systems influencing South Asia are Dharmic (Hinduism, Jainism, Buddhism and Sikhism) and Abrahamic religions (Islam, Christianity, Judaism) (Veer, 2002). Core beliefs shared by Dharmic religions include aiming to achieve enlightenment and liberation from reincarnation, and the concept of *karma,* which refers to consequences, difficulties or suffering that may befall an individual for previous wrongdoings (Bhattacharyya, 2006). Therefore, any difficulty or suffering currently being experienced is intrinsically linked to the consequences of an individual's past actions. Holding the belief that one must accept responsibility for their current situation and that relieving one's suffering may delay the resulting *karma,* or prolong and intensify it at a later stage, may prevent adherents from seeking help and treatment (Fitzpatrick, Kerridge, Jordens, Zoloth, Tollefsen et al., 2016).

While Abrahamic faiths do not share the belief in reincarnation, they do believe in resurrection in an afterlife which rewards or punishes adherents based on their actions and

behaviours in their current life (Bose, 2016). This includes how they deal with difficulties and tribulations that arise. Difficulties in one's life are often seen as the 'Will of God' within these religions, a concept which refers to events and circumstances in one's life being predetermined (Wong-McDonald & Gorsuch, 2000). While the concept of 'free will' is also apparent in Abrahamic faiths, difficulties in one's life may be accepted and endured, as scriptural verses state that devotees will not be tested with trials beyond what they can bear, and patience in affliction being a means of proving dedication to God. Adherents may also surrender to suffering, hoping to gain mental strength and eradication of past sins, resulting in a higher ranking in the afterlife and closeness to God (Hussain, 2001). The belief in 'Divine will' may result in a reluctance to seek help when suffering or going through difficulty as adherents may believe that they are lacking the patience and mental strength to cope with what God has ordained for them, and that these characteristics need to be acquired in order to deal with their circumstances effectively (Schendel, 2017).

Both belief systems emphasise wellness of the mind and human spirit, or soul, through various practices including prayer and devotion to God, yogas that train the mind, body and consciousness, selflessly serving humanity and ceasing worldly attachments (Emmanual, 2015). Although some of these faiths may not share healing practices, it is commonly believed that abiding by their respective religious teachings and values can liberate one from inevitable sorrow and suffering (Harvey, 2012; Muthuswamy, 2018). Despite the precedence of religion in the subcontinent, cultural norms and values – some of which may derive from religion – are also factors that may influence the daily lives of South Asians across the world. Culture has been defined as everyday customs, values and behaviours that are shared and passed on within a particular society (Baum, 2017). It can influence the thoughts and beliefs held towards health and healing, including the level of

stigma attached to what may be perceived as negative states of mind, what type of help is sought for treatment or whether help is sought at all (Office of the Surgeon General, 2001).

Migration to the UK has resulted in a wider range of ethnic and cultural differences within society, with various cultures holding various beliefs that are identified as either individualistic or collectivist (Kormi-Nouri et al., 2015). These two terms are often used when describing cultures in the 'Eastern' or 'Western' world, referring to the contrasts in perceptions, values and emotional reactivity for individuals who reside in those respective regions (Chentsova-Dutton & Tsai, 2010; Masuda & Nisbett, 2006; Triandis, 1990). The South-Asian culture is defined as collectivist, which emphasises interdependence within the family and maintenance of strong links within the social groups that they identify with, upholding boundaries between the ingroup and outgroup (Brewer & Chen, 2007; Carson, 2009; Darwish & Huber, 2003). In contrast, Individualistic cultures are commonly attributed to Western European countries and tend to place importance on values relating to personal needs and goals, as well as freedom of expression (Kormi-Nouri et al., 2015). Those who subscribe to this worldview tend to see themselves as separate from their social networks, which allows them to make decisions that are not generally influenced by others (Triandis, 2004). Unlike individualistic cultures, they promote a sacrificial attitude, often dismissing one's own needs for the greater good of the group, as well as actively making decisions that focus on upholding peace within it (Compton, 2005).

To do so, members of the South-Asian community abide by cultural, and often gendered, norms and values that have been internalised within the society to gain acceptance, approval and a respectable reputation, as their identity is contingent upon it (Dwyer, 2000). Within the South Asian community, the actions and behaviours of an

individual does not only reflect on their own character, but also that of their family members' (Zine, 2008). Therefore, an individual displaying characteristics or behaviours that are not accepted by the wider community, often known as the *biraderi*, may risk the family being perceived negatively within society, risking ostracisation and jeopardising future prospects for both the individual and their family members (Zaidi, Couture-Carron & Maticka-Tyndale, 2016).

To prevent this from happening, members of traditional South Asian families abide by the roles and behaviours that have been culturally assigned, often ingrained in them from a young age. For example, men are traditionally seen of as breadwinners, the head of the household and ultimate decision-makers of the family (Varghese & Jenkins, 2009). The appearance of strength is classed as an important characteristic for these roles, so male members may be brought up to perceive open displays of emotion, such as crying or sharing one's troubles, as a sign of weakness from a young age, to prepare them for the roles they must later fulfil (Hwang et al., 2008). Women, on the other hand, are taught that they are responsible for the reputation and honour (often called *izzat*) of the family, and that engaging in culturally deviant activities, such as pre-marital relationships and exposing private matters to the 'outgroup' result in bringing *sharam* (shame) upon the family (Zaidi, Couture-Carron & Maticka-Tyndale, 2016). *Izzat* (honour) and *sharam* (shame) are common South Asian concepts that are used to exercise control over the behaviour of individuals to prevent dishonour from being brought on the family, as having good reputation within society is imperative to remaining a valued member of their community (Naeem et al., 2015). Although these concepts are used to maintain moral and social order within South Asian families, they also limit an individual's expression and access to external support, as

any decision made by an individual is seen to affect others and needs to be discussed and approved by family members first (Gilbert, Gilbert, & Sanghera, 2004).

This approach is also taken when deciding the best cause of action for a family member who may be going through a difficulty (Gilbert, Gilbert, & Sanghera, 2004). Traditionally, issues are dealt with within the family home, by talking to family members. Unlike the individualistic culture, it is frowned upon for private matters to be exposed to outsiders, as this risks family image and reputation – both of which are highly important (Van Hoorn, 2015). How issues are dealt with depends on how serious it is perceived within the community. For example, in relation to health, illness in the South Asian community is traditionally understood in terms of humoral theory of excess hot or cold, which necessitates dietary manipulation to provide balance within the body and decrease symptoms of illness (Stewart, 2016). When seeking help for illnesses, South-Asians may prefer to access traditional healers due to the lack of a language barrier, the holistic approach taken and similar beliefs held towards health, unlike GPs, who were often ignorant of the use of traditional remedies (Minhas, Vajaratkar, Divan, Hamdani, Leadbitter, et al., 2015). While accessing a GP is not uncommon, members of the South Asian community may turn to complementary and alternative healing through herbalists (*hakims)* and homeopaths, as well as home remedies, if dissatisfied with treatment and its ineffectiveness (Amin, Islam, Gilani, 2015).

Unlike physical health, mental health is often stigmatised within the South Asian community and hidden from the wider society as a result (Link, Phelan & Sullivan, 2017). Cultural attitudes towards mental health and help-seeking are generally obtained from wider cultural health beliefs which tend to differ from those held by mainstream society (Sheikh &

Furnham, 2000), with culture often playing an important role in how mental illness is understood (Hwang et al, 2008). These beliefs can often arise from the meanings that cultures attach to symptoms and behaviours of mental illness which, if perceived negatively, can result in individuals and their families being stigmatised (Arora, Metz & Carlson, 2016). In order to reduce the risk of stigma, symptoms of illness may be attributed to concepts that the wider community can understand and accept (Islam & Campbell, 2014). For example, research has shown that explanations for mental illness vary between cultures, with most non-Western ethnic groups attributing issues to spiritual, supernatural, and religious causes (Snowden, 2001). These cultural attributions influence the type of help that is sought, with members of these communities frequently seeking traditional routes, such as the family, spiritual guides or religious figures (Naeem, Gobbi, Ayub & Kingdon, 2010).

This can also be seen within the South-Asian community, in which mental health conditions are often attributed to supernatural causes, such as black magic (*kala jadoo),* spirit (*jinn)* possession and evil eye (*nazar)* – illnesses resulting from jealousy and envious glances of other people (Shah & Carlsson, 2016). These conditions are often dealt with in a different manner to physical health problems, with remedies being sought through traditional healers known as *brahmin* or *pirs,* who may perform rituals and exorcisms to remove spirits or offering amulets containing scriptural verses thought to provide protection and healing (Amin, Islam, Gilani, 2015).

While help-seeking from within the community may be perceived as most appropriate for issues related to culture and faith, the stigma attached to external disclosure may provide an insight to why public healthcare services are rarely sought for more than physical issues (Sheikh & Furnham, 2000). It has also been argued that some of these

collectivist values deemed important within the South-Asian community, such as increased dependency on the social network and lack of self-governance, may negatively affect the psychological health and wellbeing of individuals, as such values often place a limit on an individual's expression of distress (Caldwell-Harris & Aycicegi, 2006).

It has been found that expressions of distress may vary depending on cultural attitudes towards open displays of emotional or psychological troubles (Hwang et al., 2008). While Western cultures may generally emphasise verbal communication and expression of one's difficulties, it has been found that members of collectivist cultures, such as the Asian community, are less likely to do so, due to the perception of open displays of emotion as a weakness. (Chun, Enomoto & Sue, 1996; Knifton, 2012). The importance of strength and the stigma attached to mental illness within this culture has been found to result in the suppression of emotions (Chun, Moos & Cronkite, 2006). As a result, the language used to communicate mental distress or illness relies on expressing symptoms physically, as this is less stigmatised (Burr & Chapman, 2004).

The degree in which distress is expressed through physical symptoms is more commonly known as somatisation, with research suggesting that it is more frequent among BME communities (Busaidi, 2010), It was found that somatising distress could minimise the consequences that an individual and their family may face from society, allowing them to instead gain support from social networks by affixing culturally appropriate labels to an illness (Hwang et al., 2008). Culture-specific terms, or idioms of distress, were often used when expressing distress (Desai & Chaturvedi, 2017); with Latino groups generally referring to chest pain, heart palpitations and gas (Dunn & O'Brien, 2009) while African and South Asian groups claimed to experience burning in their extremities or 'ants crawling under the skin' (Hinkle, 2011). It has also been suggested that women from South-Asian communities somatised distress because they were unable to communicate their difficulties using

psychological terms, referring to linguistic difficulties and differences between Western and Eastern conceptualisations of illness (Burr & Chapman, 2004; Hwang et al, 2008). However, this view contrasts with findings where South-Asian women were able to identify and talk openly about their difficulties using psychological terms to mental health workers in their mother-tongue (Anand & Cochrane, 2005). Studies have also shown that Asian service users were able to acknowledge psychosocial connections to somatic symptoms that they presented, and were capable of expressing emotions when accessing services, with physical complaints reducing significantly once they had established a strong therapeutic relationship with their therapist (Bhugra & Mastrogianni, 2004; Hwang, et al, 2008).

It has been argued that the claim of somatisation being more prominent within BME communities was related to the way in which research was conducted, often drawing comparisons between individuals in different health-care settings (Mallinson & Popay, 2007). However, numerous studies that were replicated in various countries to examine somatisation in similar settings found that majority of individuals would present their symptoms to healthcare professionals in a physical manner, suggesting that somatising mental health issues was universal and not distinctive to specific cultural or ethnic groups (Kirmayer 2001). This revealed that, regardless of ethnic or cultural background, physically expressing distress within healthcare environments was believed to be the most appropriate way in which to receive care (Mallinson & Popay, 2007). It was also found that somatising symptoms could be related to the experiences and life events of individuals, such as immigrating to a foreign country, rather than being influenced solely by cultural background (Bragazzi, Puente & Natta, 2014).

While it is clear that somatising psychological issues may be ubiquitous, one of the disadvantages that befall members of BME communities when seeking help through primary care is misdiagnosis (Tylee & Gandhi, 2005). Explaining symptoms through cultural idioms of distress to a practitioner who may not share a patient's cultural background or have an awareness of cultural beliefs towards the causes of illness and appropriate treatments may risk the patient being mistakenly misdiagnosed (Tylee & Gandhi, 2005). It has been found that practitioners taking the etic approach when treating patients has often led to inaccuracies when diagnosing service users from culturally different backgrounds (Kirmayer, 1989). The etic approach in healthcare refers to applying Western classifications of illness and diagnostic criteria to people of all background without acknowledging cultural variability in the way symptoms are communicated, assuming all individuals express distress in similar ways (Alden & Bhawuk, 2004). This perspective has received some criticism, as it risks culturally distinct behaviours being labelled as psychopathological (Kao, Hsu & Clark, 2004).

The view of symptoms of illnesses as universal has resulted in GPs, often the first port of call, being deemed inappropriate sources of help for culturally related issues (Keynejad, 2008). One example of this can be found in Healy & Aslam's (1990) study has shown that the dissatisfaction towards healthcare services led individuals from the Pakistani Muslim community of Bradford to access *hakims*–herbal medicine practitioners–if believed to be suffering from a supernatural illness, with other coping resources including religion and prayer (Hwang et al, 2008).

Despite previous studies reporting that the Asian community sought support from social networks in times of difficulty (Mojaverian, Hashimoto & Kim, 2013), the cultural obligation for group members to seek help in a similar manner has proven problematic for

individuals who have wished to access professional psychological services, as external sources of support were not considered culturally acceptable (Razali & Najib, 2000; Hwang et al., 2008). One of the reasons for this is the stigma towards mental health which, if disclosed to outsiders, had the potential to affect future prospects and honour of the family unit (Lauber & Rossler, 2007). Other existing barriers that may prevent BME individuals from utilising MHS include financial issues, an inability to communicate via a common language, and an inadequate understanding of service user needs (Memon et al., 2016).

While it is apparent that cultural beliefs and values may prevent the South-Asian and other BME communities from accessing MHS, further difficulties arise once they are accessed or utilised, as they take a traditional Eurocentric approach (Memon et al., 2016). Eurocentrism derives from ethnocentrism, which is the tendency to apply the standards of one's own ethnic culture to others without acknowledging intercultural differences (Brewer, 2016). Therefore, Eurocentrism is defined as a worldview that, based around Western beliefs, interprets the lives and experiences of non-Europeans from a Western European perspective (Naidoo, 1996). Although the United Kingdom (UK) tends to take a Eurocentric approach within psychology and public health services, it has often been criticised for not acknowledging cultural differences in an ever-increasing multicultural society (Bracken & Thomas, 2001; Singh & Burns, 2006). It has also been argued that the concept of mental health itself was developed from a traditionally Western stance towards medical research, which does not seek to understand the way other cultures conceptualise social behaviours (Allen & Sharples, 2017). Instead, non-Western cultural systems are often viewed as under-developed and inferior, which does not take into account the importance of traditional healing within collectivist cultures, as well as how illnesses in the West may not be universal to all (Fernando, 2005; Ton & Lim, 2006).

While mental health and illness have been recognised within traditional Western psychiatry, the tendency to ignore alternative cultural views elicited the use of an ethnocentric system which resulted in a rigid, limited perspective that judges all individuals similarly based on the Western diagnostic criteria developed (Fernando, 2014; Hwang, Myers, Abe-Kim & Ting, 2008). The continuous use of a Eurocentric belief system within existing MHS has resulted in dissatisfaction from BME groups within the UK due to disparities between their cultural needs and the services available (Augsberger, Yeung, Dougher, & Hahm, 2015; Bhugra, 2004; Parkman et al., 1997). This has resulted in the Black and minority ethnic (BME) communities in England, who were found to receive talking therapies significantly less to their White British counterparts, which research identifying that members of the South-Asian community were least likely to be referred to secondary services even though they experienced significant levels of MHIs (Raleigh et al., 2007; Bowl, 2007).

It was also highlighted that services accessed by ethnic minority groups limited the involvement of service users during the development of treatment, resulting in a service which did not appropriately consider specific needs that may have been of importance to this group (Blume & Lovato, 2010). Existing research identifies that health services may not be adequate for the needs of minority populations (Hwang et al., 2008) and has also emphasised the need for cultural, racial and ethnic views to be included within research and clinical practice to further enhance understanding of cultural influences on mental health (Belshek, 2006). Despite recognising that the MH needs of the BME community need to be addressed and appropriate services need to be provided (Kingsley & Pawar, 2002), it has been argued that services currently available within the public health sphere only cater to

majority economic or cultural groups, therefore remaining inappropriate for BME use (McKenzie, 2008).

Providing culturally appropriate services requires cultural competence (Whaley & Davis, 2007). Dowrick et al. (2009) describe this as the ability for service providers to offer and deliver efficient healthcare programmes that meet the cultural, social and linguistic needs of service users. Research shows that this can be achieved by mental health professionals by aiming to be culturally aware, sensitive, and knowledgeable within the therapeutic relationship, as well as acknowledging any stereotypes that they may be bringing into therapy (Milville, Rosa & Constantine, 2005; Bhui et al., 2012). However, it has also been reported that encountering culturally related issues, such as spirituality and religion, within therapy has led to therapists feeling overwhelmed and avoiding the topic when it arose (Rathod, Kingdon, Phiri and Gobbi, 2010). The inability of therapists to focus on the needs of clients who may wish to communicate openly regarding issues important to them may result in further dissatisfaction towards services (Gulliver, Griffiths & Christensen, 2010). It has also been suggested that cultural competency could be improved by investing in BME professionals, as it was presumed that racial or ethnic matching of therapists and clients may result in a stronger therapeutic alliance (Smith, 2009). While this may seem like a positive step, a study focusing on South-Asian students found that they would not be comfortable with therapists who shared their cultural or ethnic background and would instead opt for a non South-Asian therapist (Ahmad-Stout & Nath, 2013).

Despite the need to provide a service that caters to the ethnic minority population within an individualistic society, cultural competence has been criticised as being motivated by ‘political correctness’, which refers to the avoidance of language and policies that may

offend or disadvantage minority groups in society (Satel & Forster, 1999; Schwartz, 2017). It has also been argued that cultural knowledge gained cannot guarantee effective therapy and that therapeutic methods, such as the client-centred approach, are universal to all (Patterson, 2004). This view does not take into consideration that talking therapies delivered are grounded in Western values towards mental illness and treatment relies on open, emotional communication (Bankart, 1997). In comparison, some cultures of the East find that talking does not allow one to concentrate on thoughts (Kim, 2002), which shows that Western therapeutic methods thought to be universal are most likely not.

The call for cultural competency within mental health has led to the development of ethnic-specific services, mostly within the voluntary sector, although the NHS has also emphasised the need for improvement and cultural fairness within services provided (Bhui & Sashidharan, 2003). The need for a change in services has led to the development of talking therapies being adapted for ethnic minority groups (van Loon, van Schaik, Dekker & Beekman, 2013). In a systematic review conducted by van Loon et al. (2013), it was found that the study of culturally sensitive mental health interventions, based on cognitive behavioural therapy (CBT), mainly appeared in the United States, focusing on US-ethnic minority groups such as African-American, Asian-American and Latino-American. From the nine studies gathered, all based cultural adaptations on the values and beliefs of ethnic minority groups and six out of nine found that the use of culturally related adaptations had a significant effect on individuals' post-treatment (Pan, Huey Jr & Hernandez, 2011). From this, it was concluded that adapted treatments were effective if the cultural values and beliefs towards mental illness held by service users were recognised and supported (van Loon et al., 2013).

Culturally sensitive therapies for ethnic minorities have also been developed in the UK. Rathod et al. (2010) conducted a qualitative study aiming to produce a culturally adapted CBT manual tailored to the needs of ethnic minority patients with psychosis. Upon interviewing BME patients and lay-members, an understanding of cultural causes attributed to mental illness was established. This included belief in religious punishment for a previous wrongdoing, spiritual issues such as the evil eye or demonic possession, and misdiagnosis from Western professionals due to a lack of acknowledgment towards social behavioural differences. While help-seeking behaviours were influenced by cultural issues such as shame and stigma, factors such as mistrust and fear towards services were also apparent. Despite this, data gathered showed that African Caribbean participants would much rather prefer treatment through talking therapy rather than medication but emphasised that the need for cultural understanding of ethnic backgrounds was also of importance. From these findings, Rathod et al. (2010) recommended cultural awareness and understanding as the key to achieving successful results in therapy with service users from ethnic minority backgrounds.

This recommendation was applied in a recent study examining the use of culturally sensitive CBT when adapted for South Asian Muslims in the UK and Pakistan (Naeem et al., 2015). Similarly to research conducted by Rathod et al. (2010), a series of qualitative studies were conducted, using interviews with mental health professionals, patients, and lay-groups to gain an understanding of experiences of providing therapy and cultural belief systems within the Pakistani community (Naeem, Gobbi, Ayub & Kingdon, 2009; Naeem, Gobbi, Ayub & Kingdon, 2010; Naeem, Gobbi, Ayub & Kingdon, 2012). Multiple randomised controlled trials were then conducted, and it was found that culturally adapted CBT had a much more positive effect on Pakistani individuals than non-adapted therapy (Naeem et al., 2015). The

trials also demonstrated that interventions using culturally adapted CBT-based self-help manuals were also effective (Naeem et al., 2014).

1.2 Research Gap

Although researchers have begun to explore the mental health needs of BME communities in the UK, and their views towards services (Knifton, 2012; Lamb et al., 2011; Neale, Worrell & Randhawa, 2009), research focusing solely on the cultural relevancy of therapy for the British South-Asian community needs to be increased. Due to the South Asian community being listed under the term 'BME' within the UK, findings from previous studies have often resulted in generalisation towards this particular sub-population (Arora, Metz & Carlson, 2016). This is also the case when research is conducted within the Asian community, which tends to focus on East Asian ethnic groups such as Chinese, Japanese and Korean (Hwang, 2016). Failing to recognise the differences between Asian subpopulations becomes problematic in understanding differences between their needs, as those that are typical to the South Asian culture remain unidentified (Schraufnagel, Wagner, Miranda & Roy-Byrne, 2006). In order to provide a culturally competent service for British South-Asians, it is important to understand the views of this group independent from others, and research surrounding this topic has previously been explored (Bowl, 2007). While it acknowledges that existing mental health services are not appropriate for this group, few studies seek the views and experiences of British South Asians who have accessed and received talking therapy (Naeem et al., 2015). It was found that research concerned with the outcomes and effectiveness of therapy for this group was lacking, and that data investigating the ethnicity of clients and their therapists was scarce (Morrison et al., 2004; Trower et al; 2004).

1.3 Aims

Therefore, this research aims to:

- Investigate the experiences of British South Asians who have received talking therapies;
- Explore whether talking therapies are culturally relevant for the needs of the British South Asian community;
- Discover professional views held towards provision of therapy for the South Asian community.

1.4 Research questions

Consequently, the current study intends to answer the following questions:

- What are the experiences of British South-Asians when accessing and receiving talking therapy?
- How are mental health and mental health services perceived by the South Asian community?
- What are the experiences of mental health professionals who provide talking therapy to South Asian service users?

Chapter 2. Research Methodology

The current chapter details the methodological approach that guided the study. Firstly, the research design is outlined, followed by the means by which data was collected, and finally the analytic process employed within the study is described.

2.1 Research design

A qualitative research approach was employed to answer the questions developed, which sought to understand whether existing mental health services were culturally appropriate for the needs of British South-Asians. This would allow the researcher to gain an insight to the phenomenon described from the perspectives of the participants, focusing on the 'quality' of their experiences instead of their behaviours (Langdridge & Hagger-Johnson, 2013; Willig, 2013). When considering an inquiry into the topic of cultural relevance within talking therapy, information could be gathered using two alternate approaches. Data could be extracted holding the assumption that the truth is measurable and can be manipulated objectively resulting in a single reality, or, rejecting the ontological assumptions that arise from this, the world could be seen as flexible with multiple realities and truths, as the meanings attached to experiences can differ between individuals (Guba & Lincoln, 1994). In order to answer the research questions, the perceptions of South-Asian service users (SASUs), South-Asian community members (SACMs) and mental health professionals (MHPs) needed to be explored to gain an insight into the personal beliefs and views held towards existing mental health services. While the quantitative methodology has long been conducted to advance research in the field of therapy, qualitative methods have been found to further explore specific ideas that cannot be measured objectively (Barker et al, 2002). Instead, the quantitative approach has been able to seek a deeper understanding into the

views of clients and practitioner's alike, with the ability to reflect on the client's changes throughout the therapeutic process, offering potential to reveal new knowledge regarding their experiences and the ability to see the impact of this change (Gelo, Pritz & Rieken, 2015). While quantitative research in this area may explain approaches that do and do not work for clients by gathering data through categories, the qualitative approach offers participants space to describe instances that are specific to them and their growth in therapy. It also allows therapists to delve into their experiences, which can provide useful insights into why specific approaches may be used, as well as changes they may have seen in their clients.

While the research focused on the British South-Asian community, the views of mental health professionals was also important to uncover, as the beliefs they held towards cultural relevance in therapy would inevitably influence the type of therapy offered. It was necessary to gather information from each group as similarities and differences between their perspectives could be elucidated. Therefore, the relativist ontological assumption allowed the researcher to discover the meanings that these specific groups invested in their encounters with one another. The interpretivist paradigm (Arghode, 2012) was chosen to guide this research as it allows the researcher to discover how participants' unique experiences helped develop their personal beliefs and views towards mental health services. This approach was taken as the researcher held the belief that the way in which mental health and mental illness is understood is guided by an individual's exposure and understanding of the subject matter, as well how the topic was framed in their social environment and interactions over the course of their lives.

In order to delve into the meanings that each group invested in the encounters that they may have had with one another, it was imperative to interact with individuals on a subjective level (Annells, 1996). It was also important for participants to be viewed as individuals, with their own thoughts and opinions. An emic epistemological view (Pietkiewicz & Smith, 2014) was held, as attempting to objectively measure subjective experiences would not yield an accurate representation of the participants' experiences. Therefore, a phenomenological approach was employed, allowing the researcher to examine life experiences (Lewis, 2015). Phenomenology is described as a method that aims to gather *'rich descriptions of a phenomenon as it is concretely lived'* (Finlay, 2012). It is concerned with personal experiences and holds importance over individual perceptions (Smith, 2004). This resulted in the use of semi-structured interviews, which were conducted with all participants, to gain an understanding of how culturally relevant existing mental health services may or may not be for British South-Asians. Using this method allowed specific information to be collected flexibly, as well as allowing the researcher to interpret social interactions between individuals and groups (Bhui, Chandran & Sathyamoorthy, 2002; Britten, 1995; Johnson & Christensen, 2008).

2.2 Researcher's background, beliefs and biases

The research was undertaken by a female British Muslim of Pakistani origin. Having grown up within the South-Asian community, the researcher's personal beliefs regarding existing mental health services resulted in inevitable bias when data collecting and analysing. It was acknowledged that biases held would influence how data was gathered, interpreted and presented (Trufford & Newman, 2010). While methods such as bracketing may be used to lessen the effects that preconceptions have on the research process, the researcher held

the belief that distancing herself from personal assumptions, values and emotions entirely was not possible (Cohen & Omery, 1994).

2.3 Population

To answer the research questions, three groups were accessed. The target populations chosen for this study consisted of the following groups:

- South-Asian adults who had received talking therapies as clients (SASUs).
- South-Asians who had not accessed mental health services (SACMs), and;
- Mental health professionals (MHPs) of all ethnic backgrounds who had provided talking therapies to South-Asian clientele.

The SASU group was chosen to explore their personal experiences within talking therapy, while the SACM group were selected to gain an insight into wider cultural views held towards mental health and mental health services. Although the research focused on the experiences of British South-Asians, the therapeutic alliance consists of both the SASU and the MHP offering talking therapy. For this reason, it was imperative to include MHPs, as they play an important part in the therapy process and their contribution enables the researcher to understand the perspective of a professional service provider.

For this study, the broad ethnic category of 'South-Asian' was used to refer to individuals who identified ethnically as Pakistani, Bangladeshi, or Indian. While a broader range of nations makes up the geographic region of South Asia (e.g., Nepal, Bhutan, the Maldives), the researcher was unable to gain access to individuals who identify with nations outside of those formerly mentioned. Additionally, the proportion of South-Asians in the UK

who do not identify as Indian, Pakistani, or Bangladeshi is minimal (Office for National Statistics, 2011).

2.4 Sampling

Criterion sampling was initially used to recruit participants. Snowball sampling was later used to recruit further participants once data collection was underway (Ortiz, 2003). Introductions to potential participants were also made through the researcher's supervisory team and colleagues. Although criterion sampling is not representative of the general population, it allowed key individuals with relevant knowledge to be identified (Pope & Mays, 1995). The snowballing technique was used to reach individuals who may not have been aware of the study or those who may not have otherwise wished to take part. It was recognised that the sensitive nature of the study may prevent individuals from participating, as the researcher had not built rapport with potential participants prior to interview, and a certain degree of trust is needed to initiate contact (Atkinson & Flint, 2001). Therefore, referrals through acquaintances allowed some form of trust to be built before the researcher was contacted.

Participation was encouraged for all who self-identified with one of the three groups, but there was also a need for candidates to share specific characteristics. For this reason, eligibility criteria were created (see table 1).

Table 2. Eligibility criteria for potential participants

		South-Asian Service Users	South-Asian Community members	Mental Health Professionals.
Inclusion Criteria	18+	*	*	*
	Fluent in English	*	*	*
	Identify as South-Asian	*	*	
	Received therapy in England prior to interview (minimum 6 months)	*		
	Lived in England for majority of their lives	*	*	
	Offered talking therapies to SA clientele in England			*
	Ability to consent and understand the interview	*	*	*
Exclusion Criteria	Currently in therapy or psychiatric care	*		
	In a distressed state	*	*	*
	Not agreeing to consent	*	*	*
	Unable to communicate effectively in English	*	*	*

2.5 Participants and rationale for their selection

A total of 20 participants volunteered to partake in one-to-one in-depth interviews. Within the three groups, four participants were SASUs, five were SACMs and eleven were MHPs (*see table 2)*. There were a number of reasons that led to SASUs from being chosen as the sole focus of this thesis. Previous studies stated that British South-Asians were under-represented within research (Hussain-Gambles et al., 2004; Quay, Frimer, Janssen & Lamers, 2017). This group is also known to under-utilise health services despite being at a higher risk of mental illness (Waheed et al., 2015) but it was also apparent that services did not meet the cultural and religious needs of this group if they were accessed (Hussain & Cochrane, 2004). Previous research focusing on the mental health of Asians has also often failed to recognise regional differences, which resulted in generalised studies that did not include the views of South-Asians (Atkinson & Gim, 1989; Sue & McKinney, 1975).

The second group comprised of SACMs who were chosen for their views on mental health and of mental health services, as well as their knowledge regarding community and cultural views. Gaining in-depth information from individuals who had not accessed talking therapy allowed the researcher to explore similarities and differences between the two South-Asian groups. The third group comprised of MHPs who had various levels of experience working with British South-Asians. This group was chosen to gain an insight into thoughts and experiences of professionals as service providers.

Table 3. Demographic information of participants

	Gender		**Ethnicity**		**Religious Affiliation**		**Occupation**	
	F	**M**		**N**		**n**		**n**
South-Asian service users	4	0	Pakistani	4	Muslim	4		
South-Asian community members	3	2	Pakistani	3	Muslim	4		
			Bangladeshi	1				
			British African South-Asian	1				
Mental health professionals	9	2	Bangladeshi	2	Muslim	3	CBT psychotherapist	3
			Indian	1	Hindu	1	Medical psychotherapist	1
			Persian	1	Christian	2	Assistant psychologist	1
			Chinese	1	**Unaffiliated:**		Trainee psychologist	1
			White European	2			Psychotherapist	2
			Somali	1	Agnostic	1	Integrative counsellor	1
			Black	1	Atheist	2	Support worker	1
			Caribbean	1	Undisclosed	2		
			Mixed heritage	1			Undisclosed	1

The sample size within each group was determined by considering the recommendations of qualitative researchers, accessibility of participants and availability of

time and resources. Achieving '*saturation*' is a term often mentioned within purposive sampling (Byrne, 2001; Fossey, Harvey, McDermott & Davidson, 2002), referring to the continuation of sampling until adequate data has been collected (Walker, 2012). Despite saturation becoming a '*gold standard*' within qualitative research (Guest, Bunce & Johnson, 2006), there were a lack of guidelines provided to estimate sample sizes to achieve saturation (Morse, 1994). This method also did not take into account time as a limitation during fieldwork (Cheek, 2000). There are, however, existing guidelines that have provided acceptable sample sizes for qualitative research of various approaches. Bertaux (1981) stated that a minimum of fifteen interviews were adequate in qualitative research, while Morse (1994) recommended six participants for phenomenological studies but thirty or more for other qualitative approaches. Creswell's (2007) recommendations ranged between five and twenty-five interviews for a phenomenological study while Kuzel (1992) recommended six to eight for homogeneous sampling. The recommended sample sizes from respected researchers varied. While many interviews may guarantee saturation, it would reduce valuable time needed to remain immersed in fieldwork to address the research problem in-depth (Crouch & McKenzie, 2006). This combined with potential reservations contacting the researcher meant saturation was not possible.

After much deliberation, it was decided that the sample size for each group would be ten. Although the focus of the study was based on South-Asians who had experienced talking therapies, it is apparent that the sample for this group was relatively small in comparison to the other two groups, especially that of MHPs. There are many possible factors that prevented SASUs and SACMs from participating. It has previously been stated that a multitude of barriers prevent this particular ethnic group from engaging in mental health research (Waheed et al., 2015). Some of these barriers included a negative attitude to

help-seeking, a lack of trust, family perspectives, and stigma (Brown et al., 2014). The researcher's position as an 'insider' may have also affected participation. While this position had the possibility to create shared understanding and empathy (Bhopal, 2010), it also allowed the researcher to gain access to sensitive information. This may be considered risky by potential participants, as the South-Asian culture emphasises keeping issues within the family due to '*izzat'* (honour) and '*sharam'* (shame) to prevent tarnishing the family name within the community (Soni, 2013). Ethical restrictions may have also resulted in the lack of participation from SASUs as those who were currently users of charities and voluntary organisations were automatically excluded. The barriers stated, and time constraints of the thesis prevented the sample size from being achieved for both South-Asian groups.

2.6 Procedure

Specific charitable organisations in England were contacted to identify potential participants. Regions included the North-West, the West Midlands, the South and East of England, and London. A list of these can be found in the appendix (see Appendix A). Organisations were no longer contacted if a response had not been received after three attempts. The study was advertised through posters at the University of Bedfordshire's Luton campus, on social media, via email and through local places of worship. A recruitment email was sent to the PsyPag Postgraduate Research group which had access to a wide range of potential participants. Candidates were asked to indicate interest via email and were sent a participant information sheet (see Appendix B) with the opportunity to ask any questions. Interested participants were contacted to ensure they met the eligibility criteria. They were also asked if they were currently seeking therapeutic help, under psychiatric care or in a

distressed state. Suitable participants were emailed a consent form (see Appendix C), detailing what the study would entail.

Potential participants were informed that the aim of the study was to gain a deeper understanding of their experiences either in therapy, as a community member, or as a mental health professional. A total of 26 potential participants contacted the researcher, of which 20 took part. Once candidates agreed to participate, they were asked to meet at a designated time and place. Acknowledging the sensitive nature of the topic to be explored and vulnerability of service users, the option to conduct interviews via phone-call or video-call was made available to ensure comfort. This option was also available to participants who lived further away from the University of Bedfordshire, as it became apparent that the lack of reimbursement for travel costs was an issue and prevented interviews from taking place. Six interviews were conducted face-to-face; one at the University of Bedfordshire and five at a local mental health organisation. Eleven participants opted to be interviewed via phone-call while the remaining three opted for video-call.

Three semi-structured interview schedules (see Appendix D) were specifically developed for each group. Both the participant information sheet and introduction provided by the researcher emphasised the importance of participants sharing their experiences. The interview schedules were used to ensure all topics were covered, and prompts were used where necessary. All interviews were conducted in English by the Principle Investigator, a British Muslim female of Pakistani origin. To begin, participants who participated in the face-to-face interviews were provided with a hard copy of the information sheet and given the opportunity to ask any questions. Written consent was obtained, and demographic information (see Appendix E) was collected. Participants were asked to provide a

pseudonym that could be used to identify them if they decided to withdraw their data at a later stage. Participants who opted for phone- and video-call were communicated with prior to beginning the interview to make sure the information sheet was understood, and consent form signed and emailed back.

Permission to record the interviews was requested from participants and was granted by all. A distress protocol (Haigh & Witham, 2013; see Appendix F) was used throughout the interviews to prevent harm to both the researcher and participants. If the participant showed signs of hesitation or distress, they were communicated with to establish whether it was safe to continue and reminded of their right to pause or withdraw. Interviews lasted approximately 30-90 minutes. Each of the interviews were digitally recorded using a Trustin portable Dictaphone. The pseudonyms were changed to codes within the final write-up to reduce the risk of being identified. Once interviews were complete, participants were again asked if they had any questions, were reminded of their right to withdraw and provided with a debrief form which listed organisations if further help was needed (see Appendix G). They were also reminded that the findings would be made available to them after the data was analysed and written up. Transcripts were stored on encrypted files on a password-protected computer.

2.7 Data analysis

An inductive thematic approach (Braun & Clarke, 2006) was employed to analyse and identify recurring themes and patterns across the data corpus. In the initial phase of analysis, the data collected from all interviews was transcribed verbatim using an online software, oTranscribe (See Appendix H). Interviews were listened to multiple times before the recordings were destroyed in order to guarantee exactness within transcripts, and

transcripts were read repeatedly to establish immersion with the data, with initial ideas and possible themes being noted (Riessman, 1993). Thus, began the second phase of analysis, in which initial codes deemed appropriate to the research question were manually identified. The entire data set was given equal attention and coded transcripts were analysed multiple times to ensure codes were accurate throughout, recoding if necessary. This led on to the third phase, in which latent themes–identified interpretively–were developed, using tables to organise coding into similar categories (see Appendix I). Themes for each participant group were developed separately and consistently measured against the questions developed to make sure they were suitable. This resulted in the development of initial thematic maps (see Appendix J) for each group, which allowed the researcher to visualise the relationships between the main- and sub-themes. Themes were then reviewed within the fourth phase to identify whether they were suitable. Codes relating to each chosen theme were placed within another table consisting of thematic categories (see Appendix K). Those that did not support or relate to the research questions adequately were discarded, while others which deviated from the majority were kept to explore why differences arose. At this stage, some themes were discarded, others were created into new themes or collapsed into existing ones. Once a narrative for the remaining themes was established, the initial thematic maps were refined, and a final thematic map was developed for each group (see Appendix L). Themes were defined and named within the final phase of analysis, and extracts that provided a clear example of individual themes were chosen.

2.8 Ethics

Ethical approval was granted by the Research Centre for Applied Psychology (RCAP) at the University of Bedfordshire. The guidelines set by RCAP and the British Psychological

Society BPS; 2010) Code of Human Research was adhered to throughout this research. Respect for participants was of utmost importance. The researcher was conscious of the importance of maintaining a non-judgemental, warm and friendly stance throughout all communications with participants to build a positive rapport and ease any worries they may have. Children and young adults below the age of 18 did not take part in this study due to its sensitive nature and the affect this may have on their mental wellbeing. Participants were made aware of their rights for privacy, which entitled them to anonymity and confidentiality; this was emphasised throughout. Participants chose their own pseudonyms which allowed them to be identified if they wanted to retract their date at any point during the data collection period. The names of individuals, organisations and regions mentioned which may identify the participant were also redacted. There was an awareness of individual and cultural differences and participants were reminded of their rights to withdraw from the study at any time.

Chapter 3. Findings

This chapter aims to identify patterns and key concepts that emerge from the responses of semi-structured interviews conducted with three groups of participants: SASUs, SACMs and MHPs. Patterns were identified in each group independently through the use of inductive thematic analysis and are described below. Verbatim extracts will be presented in italics and multiple quotes will be used within each theme to provide a deeper insight. With the research topic aiming to answer a specific overall question, there will be an overlap in ideas across interview groups. A synthesis of these ideas will be presented in the discussion.

3.1 South-Asian Service Users

What are the experiences of South Asian service users when accessing talking therapies?

Initial apprehension towards access

All participants within this group reported feelings of anxiety and apprehension when accessing talking therapies for the first time as they were uncertain of what it would entail and were not used to communicating in the manner that is common within therapy. This often led to thoughts of refusing access before attending, mistrust towards the service and a fear of being judged by therapists.

> *I was a bit apprehensive at first because it was the first time I was going to open up to a complete stranger … I didn't know who my therapist was going to be until the first session. So, at that point, when I did get the appointment, I was quite anxious, and I did think of pulling out and not going ahead. So, it was a bit daunting, to be honest, because you're not expecting what's going to be there. You know. Or how they're*

going to understand what you're relating to. So, it is, it is a bit, erm, scary, I think, in my- I was quite scared as to what would be happening in that session. [SASU1]

Erm, so I started off with erm, a male therapist and I mean, it was a very weird experience because I've never really seen a therapist before and it was just very awkward for them to just sit there and you just basically talk, and they just listen. [SASU4]

… and so even when my mum did suggest seeing a therapist, erm, I even questioned it, like why would that even help? Just talking to someone I don't know? And they don't know anything about me, I don't know anything about them, so how could they possibly help me? Erm, so I think it's just that. And plus, like, you wouldn't want someone you don't know judging you and telling them your whole life story. [SASU3]

There was also no consensus in the approaches taken by SASUs to gain access to mental health services. Throughout the interviews, it became apparent that therapy was only accessed when the opportunity to receive it was personally offered by a third party. While participants acknowledged the issues they were facing, they were either unaware of existing services or questioned whether accessing services was necessary.

… she had referred herself through the police to get help to speak to somebody … therefore, they said as a carer of a survivor, it would be good, so I could air my views and actually deal with the issues that were you know, surrounding that. [SASU1]

I mean, I was really stressed at work and they usually tell us as soon as we start at placement that you know, "You have this option", to use it, and "We recommend that you do use it". [SASU4]

But I think that was one of the things that was just always in the back of my mind. Like, is it a weird thing for someone at my age to be getting counselling? Is it weird that I've got these issues? Stuff like that, and should I be going to therapy at my- do I need it? Do I not? [SASU2]

Fear of disclosure tarnishing family image

Disclosure of personal issues was widely acknowledged as something that does not occur regularly within the South Asian community due to the impact it has on an individual and their family. Importance of family image within the South Asian culture was mentioned frequently, with the expectation of being perceived as 'perfect' by the wider community preventing disclosure to outsiders and causing a barrier communicating openly within therapy, as can be seen in the excerpt below from participant SASU4. Cultural perceptions towards mental health and those suffering from it resulted in the need to be discreet about problems faced, as disclosure had the potential to negatively affect family standing, bringing shame upon them. This often resulted in mental health related issues being dismissed or blamed on external factors.

We deal with things as and when it happens, we're not really allowed to speak out because of shaming the family or bad naming your husband, so even though people know there are services available to us, it makes it very difficult for us to actually

access those. Erm, because we think hang on, if we go outside, somebody will know about our background. That again will bring shame on the family. And in society, we won't be the perfect little unit that people expect us to live as. [SASU1]

I think, in the culture, it kind of seems, I think mental health issues as a whole are seen of a kind of taboo thing. I think people just kind of see, I think people in our culture just see mental health as someone being... excuse me for saying this, but someone just being crazy. I think, I honestly think that's what they see mental health as. They don't actually see it as you know, a whole range of different things. Like someone having something happen in their life, and then being affected by it, or you know, losing someone - that can cause mental issues. A lot of stuff, and they just see it mainly as someone having gone crazy and no longer wants to do anything with their life. [SASU2]

I think they [community] don't think that it's the done thing. They prefer it if you just forget something ever happened or they want you to just talk to someone about it in the family rather than telling people outside what's actually going on because they like to kind of have this, erm, reputation thing of oh, everything's perfect within the family. And they'd rather not anyone else know what's going on. [SASU3]

I mean, she'd [the therapist] try and ask and I would just like, give one-word answers and be like, oh yeah, you know, things are great *at home! We all get along* really *well! Parents are* really *supportive! So, it's just- you just- I mean, where you've grown up like that, you just don't do it because you're so used to it. [SASU4]*

They'll say, no, no, she's on medication. Or they'll just blame it on stuff or brush it under the carpet. [SASU3]

Therapist's commitment to service user enabling disclosure

The views SASUs held towards talking therapy prior to receiving it changed dramatically once it was accessed. All participants but one stated that they were put at ease and felt comfortable within the initial few sessions, with negative feelings dissipating once they witnessed genuine care and began to understand the role of the therapist within the alliance. This realisation, along with rapport built, enabled participants to disclose issues without the hesitancy of their initial worries.

So you sort of build that relationship, that rapport with her, and then that helps you because you know- I wouldn't say their secrets, but you know about their *life and you know that they're willing to share their experience and their inner thoughts with you and it's not just erm, somebody sitting near the chair writing stuff down, not taking anything in, erm, not being open with* you *honestly… it put me at such a ease that I was able to discuss* anything *with her… That was through her allowing me that time to get to know her as a person, and you know, building trust which helped that I can speak to her about anything. [SASU1]*

… once I'd actually settled in and got to know my therapist, erm, I began to feel more comfortable and stuff. So, I felt like I could actually talk to them and speak about stuff that was on my mind whereas before that, I didn't really feel like I could speak to

anyone about what was going on… I'd say within the first few sessions, I felt quite comfortable with her because she was quite, you know, welcoming and open. [SASU2]

Therapists having a good understanding of the South Asian culture also had a positive impact on the therapeutic alliance. On the occasions where they were not culturally aware, therapists utilised their personal time to explore topics through research, which resulted in increased comfort and trust, as participants felt valued within the relationship. Overall, participants stated that their decision to access therapy was beneficial to their personal growth and all were happy to re-access services again if needed.

Erm, so I think for me, her trying to understand a little bit more about where I came from made me think that she actually understood me as a person and she valued me. I wasn't just another person that was paying her her salary. She wanted to help me. She wanted me to move on with my life. And to help me do that, she sort of, started to understand where I was actually coming from. So, I think that helps; knowing somebody's there for you and they're willing to, you know, use their own time, their own energy, to learn a little bit more about you and your lifestyle. [SASU1]

So like, when I spoke to my therapist, erm, and I would tell her stuff like you know, that this is how it is in this culture, she would actually like, before my next session, erm, she would have found out a bit more about my culture, so then if anything did come up, erm, she already kind of expected that, as she knew. She read up a bit about the culture so I found that a bit easier then… Erm, I found that, that made me kind of be able to trust her a bit more and open up to her a bit because I felt as though she

understood me better. And I didn't have to like, keep trying to explain things because she already kind of had the knowledge of it. [SASU3]

Obstacles related to therapist's gender, ethnicity and cultural awareness

A lack of cultural awareness within therapy became a barrier to disclosure and resulted in a refusal to return to the therapist if participants did not feel understood. On one occasion, the participant linked the lack of understanding to the gender and ethnic background of the therapist. As a female service user, the therapist's gender became a barrier to disclosure as the participant believed that the male therapist would be unable to understand issues that affect women. This resulted in the participant being transferred to a female therapist. Although the barrier to general communication decreased, the issue of limited cultural understanding was still prevalent, leaving the participant dissatisfied.

… we felt like we just weren't making much of a connection. He was a White man … And it was just - there was no kind of connection because he wasn't very well, you know, he didn't know much about, you know, the Asian culture, et cetera, et cetera, so it was a bit weird. So, then I moved to a female therapist who was still White, but she still didn't understand… but we had more of a connection, we got on a lot better. But, it was still a bit, you know, certain things I'd say, she wouldn't really, you know, understand. And she'd try and, you know, give some advice, but it wasn't very relevant, so, yeah. [SASU4]

I mean, it was weird, because usually you- when you talk about personal stuff or how you feel, you talk about it with your girls, not a man, so firstly it was really weird

because of that. Erm, and I don't know, I just didn't feel like I could open up and stuff with him … I just really put up this big sort of block wall and I wouldn't open up about anything, so that kind of- I think, because it was a man, I struggled to open up and the fact that he was White, he just obviously didn't understand so there was no point me going into detail. [SASU4]

In another case, the participant chose to transfer from private therapy to therapy offered within an educational institution due to financial implications and found that the level of cultural understanding and rapport between therapists differed, which had a negative impact on progress within sessions and resulted in the service user ending the therapeutic alliance. It was stated that this negative experience could have resulted in a refusal to re-access if the participant had not previously encountered a positive experience.

After her, because that was erm, private and it did end up being quite expensive, I was told that there was a counselling service at college, at the college I was at, and the waiting list there wasn't very long at all. So, I was able to see a therapist at college… Erm, I, overall, I don't think that was as helpful as it was with my first therapist. I wasn't really completely comfortable with this therapist. I think I only probably saw this therapist about three or four times. Erm, and I just stopped because I wasn't finding it very helpful at all... I think she just... I don't think she was understanding me very well, or... yeah, I think that was it. I didn't feel as though I could be completely open with her. She was, she seemed like a bit, erm... not as welcoming, or... or warm as the other one, if that makes any sense. [SASU3]

Erm, but now having been through that, I know that it really can help, and I also think that the therapist is also like a big process of that. Whereas if I didn't have erm, my first therapist and I only saw the one at college, I wouldn't have found that very helpful at all and I don't think I would have carried on going. [SASU3]

The importance of being understood from a cultural perspective was apparent throughout the interviews. Despite the predicament of potentially not being understood by a White British therapist, there was a general agreement that therapists sharing cultural or ethnic background with participants would not be accessed due to a lack of trust and fear of judgement.

… if somebody is the same culture, same tradition as you, instead of being erm, a listener and just offering, you know, listening to what you've got to say, people will tend to judge you. [SASU1]

Erm, I think I found it easier talking to someone [who] wasn't like, the same as me, so who wasn't Pakistani, because I felt they wouldn't, I dunno, I think I just felt as though they wouldn't judge me and stuff like that. I think it might have taken me longer to, like, open up and trust the person. So, I think it really did help that the person wasn't of the same ethnicity as me. [SASU3]

Erm, see, if I was to say– if it was an Asian therapist that– I feel like I would not open up at all *if it was an Asian therapist. I would not say anything because I thought I'd be more judged… Asians are all judgemental - that's very stereotypical, I don't know. I*

feel like Asians are quite judgemental at times and I just, I don't know. I've always just, I've never opened up to an Asian person ever. Never. Because I just always thought, oh crap, they're judging or they're thinking this or what are they going to think of me or, I don't know. Because obviously they have the same culture and they're more kind of well-versed in it and I just, I don't know, I've just always thought they were more judgemental. I think it's got a lot to do with growing up around those kinds of people. [SASU4]

3.2 South Asian Community Members

How are mental health and mental health services perceived within the South-Asian community?

Inability to acknowledge symptoms as mental health conditions

It was articulated that there was an apparent lack of acknowledgement towards mental health and mental health issues within the South-Asian community. Participants stated that this was due to the lack of mental health terminology within various South-Asian languages spoken, as conditions could not be understood if individuals were unable to attach meaning to behaviours or describe them adequately to others.

... I'm not sure there's particularly much acknowledgment of mental health or even erm, a recognition of mental health being a valid concept within the community. Erm, when it comes to health and wellbeing and illness, the only real discussion surrounding it relates to erm, physical wellbeing. So, things relating to mental wellbeing seem to not even be mentioned, erm, and in those instances where they are

mentioned, they're not used in the clinical sense, or in relation to mental health in a erm, in a way which demonstrates an understanding of mental health. [SACM4]

And I think one of the distinct things about mental health, especially within the South-Asian community- or at least the community that I've been brought up in- is that there's not really *any, any language relating to mental illness. So yeah, that lack of language there to describe a condition just makes it seem as though the condition doesn't exist. Especially when you have to describe it using symptoms. [SACM4]*

This led to the denial of mental health, not acknowledging or seeking to understand why issues occurred, due to the negative connotations held within the community. Participants explained that the topic of mental health was labelled a taboo as there was a tendency for the community to shun those who displayed socially unacceptable, or 'abnormal', behaviour.

I think it, sort of, not- obviously not everyone, but for some people in the South-Asian community, where if they'd have their kind of like, have their backs up, kind of attitude towards mental health? Like they'll immediately shy away from it, just because it's not spoken about, like you said, and it's just, just… I don't know. I think it would put people off. With, if, I see, if you, I see it like, if you come from a family where these sort of traditions, these South-Asian traditions are very important and fundamental to your living of your life, then you would shy away from these sorts of things. [SACM3]

I think there's a, it's very black and white. So, it's either considered that you're mentally healthy or you're insane. And there's no real grey area in between those. Erm, the term used is, erm, saying, you know, "They're mad." as in they're not in, they're not in control of their senses and rather than being helped or being treated, generally it's seen as they need to be shunned. [SACM4]

Erm, I know that people don't like talking about it, erm, you know, it's somewhat like a taboo sort of thing… The way mental health was portrayed, and the way people act around it and the stories that you hear would be very, very, sort of like, disturbing in terms of like, oh my God, the person's - you know, they consider the person an imbalanced person, you know. It was almost like a shame to have someone like that. Erm, and they'd be looked down upon, and so forth and so on. [SACM5]

Failing to recognise conditions often resulted in mental health issues becoming visible once individuals reached crisis point. When issues were no longer able to remain hidden from the public eye, they were blamed on external factors and dealt with by accessing traditional sources of help. In the few cases where mental health services were accessed, it was done covertly to reduce the risk of judgement and negativity from the community.

…if they're very orthodox, people tend to bury their heads a little bit and maybe go the route of erm, "It's not depression, it's not a mental health condition, it's black magic. Somebody's done something and that's what's causing our relative to behave in this." And they spend so much time and so much effort and so much money on

seeking soothsayers to fix their family member, that by the time they actually realise that look, this is really *a medical condition, it's nothing to do with anything else, that it's probably too late for the family member… They've gone so far that they could have been brought back maybe, from just counselling or talk therapy or erm, early intervention medication. But they've left it so late because they've wanted to deny the fact that it's a medical condition, that they've actually helped contribute to making their family member worse. [SACM1]*

You don't want everyone to know that you're going. What will people think if you are going? You know, "Such and such had gone into therapy", you know, "I wonder what's wrong with her?" You know, the whole gossip thing that you have within each culture? I think it's to do with that, I think, more than anything else. [SACM5]

Expressions of distress as culturally unacceptable

It was explained that cultural upbringing emphasised individuals maintaining an image that would not affect the social standing of the family, as there was power associated with an untarnished status. Anything that would risk the family being perceived as 'weak' was discouraged, including open disclosure of personal issues.

I just like, erm, maybe just the idea of you know, not speaking about your problems to people outside the family. I know that's a problem in the Asian community. Like, you know, not, just not airing your problems and whatnot, to people that you are not you know, family, you are not close to or whatnot. I dunno, yeah, the privacy thing, the

privacy thing I feel in some families, and that can probably stop someone from using the services. [SACM3]

There's that whole idea *of the comm- whether the community would say anything or not, I'm not sure, but the South-Asians have this thing of not wanting what is perceived to be weakness or being lame to be presented to their community. So, they want to maintain this image of being strong and stoic and happy. [SACM4]*

This was further demonstrated by the focus placed on cultural gender roles, in which men were considered breadwinners who very rarely expressed emotion and women were expected to uphold family honour through their actions, abiding by social norms to prevent shame.

Erm, I think within the Asian community a lot more, I think it's a problem because men have to be the breadwinner. They have to be macho, they have to be the ones that are taking care of the household and they're very aware of that from a very young age. And I think they see it as a weakness to... for people to see them with a mental health illness or the fact that they have to take medication, or they have to go to a counsellor, they find it really really difficult to accept- accept that really. [SACM1]

I think they will find it very difficult to understand the makeup of the households and the guilt that a lot of women, South-Asian women, is bred into them basically, from a very early age. That they, you know, they have to be really good wives, they have to be really good daughters, they have to be really good sisters. They have to be, you

know, really good nieces- they have to be just the best that they can be, and no stain must come on them, at all*, from* any *aspect at all, and that burden is very difficult… [SACM1]*

Perception of services lacking cultural understanding

The importance of culture and family within the South-Asian community resulted in a fear of not being understood within services if they were accessed. There was a common belief that Western professionals would not understand the cultural background of South-Asians, often resulting in individuals fearing judgement from therapists and refusing to re-access if the service did not cater to their needs. This often lead to service users verbalising their dissatisfaction to others, which further hindered the use of services if they felt they would not be taken seriously.

… for example, South-Asian people, we are from collectivist culture and it's difficult for, let's say, a European or American doctor to understand that like, family is really kind of, in the choices we make… [SACM2]

… I think it's just like uncomfortable *going to someone who... probably won't be from* within *their community, er, trying to help them. [It] will just be like "Oh, I don't know, I'm not sure." Like you know, is, like you know, Jane or Susan or Dave or Steve gonna understand me? It's like, probably not. Whereas if you had someone who they felt like they could relate to, maybe they'd be more comfortable, or at least* less uncomfortable *going to them. [SACM4]*

… but some of the most obvious points I could think of is if the person on the opposite end cannot grasp the culture, cannot grasp the issues within that, because you know, they've not seen it or experienced it, they just can't bring themselves to put themselves in that person's shoes and understand those complexities, then they will not be qualified to help that person. [SACM5]

Well, they just refused to access the services again. They don't think there's anybody there to help them. They've come out feeling hopeless. Erm, and thinking, "well, there's nothing out there for me, nobody understands me, nobody gets me, maybe it's me*." You know. "Something's not right with me, nobody gets me, nobody understands me." and I think it's erm, crucial, that there are more services available that are* more *open erm, to the cultural aspect, really. It's such a huge part of Asian er, SA women's lives; the cultural aspect. If, if you can't understand that, then you won't be able to understand where that individual's coming from and they will just- yeah, a lot of, a lot of my friends that have accessed these services have not gone back to them. [SACM1]*

Traditional views towards mental health redefined through education

Positive perceptions towards mental health and accessing services was linked to education. The increase in mental health literacy and understanding the benefits of talking therapy enabled individuals to place less emphasis on cultural perceptions. This reduced the insistence on maintaining family image within society and allowed families to support and seek help for those who needed it. The change in personal perceptions positively influenced

individual decision-making and willingness to access services as there was no longer a focus on the views and beliefs held by others.

> *Whereas if you come from a family where, you know, traditions like these are not as influential in your daily life, then maybe you'd be more open to it and your own personal feelings and thoughts and whatnot would influence you having therapy. If that makes sense. So, if you came from a really traditional family where you know your family wouldn't be comfortable with this, then that would kind of stop you from exploring the whole idea of therapy, but if you came from a more relaxed background, you know, to do with this, then it would, it could go either way. You can either be, okay, maybe I'll try this, or explore it, or, you can just have your own personal feelings of, no, I don't want to do this. [SACM3]*

> *The South-Asian community has become very, very aware and very open, erm, to mental health. I think because there's so much of it now. Everybody knows somebody who's, who's got either got depression or has a er, a MH condition. Everybody has somebody you know, within their family that they can link up to. So, I don't, I don't- I think people are very open and very willing for family members to seek help and get the help that they need. [SACM1]*

3.3 Mental Health Professionals

This section will explore the experiences of mental health professionals who have previously offered talking therapy to South Asian service users. This group has been divided

into two sub-groups consisting of South-Asian (SA-MHP) and non-South-Asian mental health professionals (NSA-MHP), presenting both groups separately in order to identify similarities and differences between them. The abbreviations SA-MHP and NSA-MHP will be used within this section.

3.31 South-Asian Mental Health Professionals

What are the experiences of SA-MHPs when working with SASUs?

Cultural and institutional barriers obstructing access to therapy

SA-MHP's within this group differed in the amount of time they had been practising talking therapy, but all verbalised issues that could prevent SASUs from accessing it. Participants acknowledged the importance of culture within this specific user group, which influenced the way issues were perceived and dealt with, including the taboo towards mental health, the emphasis on enduring problems privately and the importance of gender-related expectations. These cultural expectations resulted in stigma towards disclosure and accessing external sources of help, posing the risk of judgement and ostracisation from the family and community if individuals were seen to undermine cultural parameters.

> *I think... erm, apart from what I've already mentioned… if the woman hasn't got independence. And I think for men as well. There's this thing of, why would a man... like, you expect- the community kind of expects that men should be fine and strong and all the rest of it, erm, so for them to access services is just like, well, that's showing weakness. [SA-MHP1]*

… like, in very traditional families- and when I say traditional, I mean culturally traditional- it's literally a view of you stay at home and you take the situation, whatever it is, you don't speak about it, you be patient and their definition of patient is not speaking out, not doing anything to change it. [SAMHP1]

I used to hear a lot in the past that you know, you should... wash your dirty laundry within... not go out there, you know what I mean? There's a saying. There's a little bit still erm, that you shouldn't talk to stranger, talk to other people about family issues and problems. [SAMHP2]

I remember talking to residents who were from a SA background and some of the stigmas that they faced were like, you know, if they were accessing services, difficulty with accessing services. You know, "You're not welcome in our mosques.", "You're not welcome in our family."… Quite a lot, really. It's like, if you've got a diagnosis, then you're basically doomed. [SAMHP3]

The cultural stigma towards accessing external sources of support caused an under-representation of South Asians in mental health services, often due to individuals being unaware of the therapeutic process. In cases where services were known to individuals, the views held by the community and by extension, the family, were found to influence the individual's decision towards help-seeking, as well as whether they would share their experiences of accessing therapies with their community.

Er, self-referrals were not very common because they didn't understand *what counselling involved. [SA-MHP2]*

Yeah, so the stigma first of all, with regards to accessing therapies, it's still like, you still don't - like I said, people access it but they don't talk about it to other people. They don't tell them, "Actually, I'm getting a bit of help because I need it." I think people are always thinking, oh, I'm going to be judged and I'm going to be looked down upon and I'm going to be talked about and no one's going to understand, it's going to be more stress, there's going to be people knocking on my door, questioning me, all of that kinda thing. [SA-MHP1]

If the decision to seek external help despite the cultural implications was made by a South-Asian individual, SA-MHPs found that they often faced difficulty accessing services through a general practitioner. It was stated that GPs who shared a cultural or ethnic background with South Asian individuals would often hesitate to refer them to talking therapy despite access to services specifically being asked for, as there was a tendency for GPs to hold traditional cultural beliefs regarding disclosure of personal issues. This was due to a lack of understanding around therapeutic services and its benefits, which resulted in the need for them to be educated on the topic. On occasions where GPs did refer individuals to talking therapy, lengthy waiting times would prevent access when it was most needed and caused difficulty finding other suitable routes, as individuals were not aware of them.

I have heard lots of clients saying, 'I asked my GP to make a referral and they say "Why do you want to go to a stranger? If you have a family issue, why don't you sort

it out with your mum or dad?"' GPs themselves would make remarks like that. So, we had to do a lot of work going around doing presentations in GP surgeries or GP forums and things like that, to educate. They themselves didn't actually understand what counselling involved, or any of it. [SA-MHP2]

It's a very complicated system. Like, people don't know, like, who do you go to? Do you go to your GP? And if you go to your GP, it takes so long, erm, and it's just like, well, that's going to take so long, who else do I go to? And most people won't know who else to go to, what other options are out there. So I'd say access is really difficult. [SA-MHP1]

When access to talking therapies was gained via a GP, SA-MHPs reported that existing mental health services lacked cultural awareness and did not do enough to cater to the needs of SASUs, such as providing adequate resources in South-Asian languages for those who could not speak or understand English fluently. However, there did seem to be some understanding that mainstream services may not be the most suitable for SASUs, as they were often referred to culture-specific services within the voluntary sector.

Erm, for example, like, whenever I'm trying to tailor my *sessions, one of the struggles* I *have is, I can't find a lot of resources in their language. Erm, you find the odd work-sheet but you can't find a lot of it like you can do in English. But I think little things like that. Erm, most services should offer an interpreter, not always they do. [SA-MHP3]*

We were inundated with referrals because erm, professionals with the mental health mainstream sector or otherwise feel that we would be appropriate to work with Asian therapists and they carry on making referrals. [SA-MHP2]

Mental health professionals' preconceptions

While all SA-MHPs were generally accepting of SASUs, one SA-MHP, who worked in a service that initially catered for predominantly females, explained that she had not considered conducting therapy with male service users, due to the presumption that males would find disclosing to female MHPs difficult. Although the SA-MHP felt that stronger rapport may be built with a male MHP, it was also understood that male service users may be open to receiving a female perspective.

Erm, well initially, I didn't consider it myself because I just thought it would be too awkward for a male client to talk to a female counsellor. I think they would have more of a rapport with a male. Erm, but the other thing is that the service provider that I was working for was also, the service at the time was mainly for females. By now they've opened their doors so they take males and females. But I don't know, I think... I think some things men may potentially feel that they can't discuss with a woman, but other things, they might actually feel that actually, I prefer to tell a female, get the female perspective rather than tell a man. So I think it does vary. [SA-MHP1]

Challenges in therapy related to SASUs cultural views

Although SA-MHP's felt that therapy sessions with SASUs were generally positive, they also expressed several challenges that arose within them. SASUs had difficulty differentiating between their faith and culture and were often unable to challenge the issues that arose from these beliefs. The similarities between the SA-MHPs and SASUs cultural and religious backgrounds had a positive effect on the service users' progress where cultural issues were concerned, as SA-MHPs were able to provide insights and guidance that the SASU could relate to. However, sharing a cultural background could also be problematic within the alliance, as the cultural similarities and the service users' lack of understanding towards professional relationships could cause boundaries to be overstepped, with SASUs often mistaking the alliance for a mutual friendship.

> *A lot of what I've seen is, people have been following their culture thinking that it's the same [as their religion]. And then it's trying to make them understand that actually, that's got nothing to do with the faith and you don't have to follow that at all… Erm, obviously, that's like a massive erm, life shifting, you're shifting your whole focus in life, it's a transformation, basically. Erm, so that's been the major challenge that I've seen and that's the most, in my work, that's what I'm trying to deal with at the minute. Trying to combat some of these misconceptions related to the faith er, where people have imposed cultural norms. [SA-MHP1]*

> *But usually good and er... well sometimes, that doesn't always play in your favour because they sometimes may think that we're more friends, and not on a professional level, in that sense, where sometimes they have that sort of attitude, but that just needs to be addressed. [SA-MHP3]*

Er, I keep it very professional. That's the one area I struggle with actually. Because obviously, people coming from a Muslim background, it's like "You're my sister in Islam, so I'm going to be friends with you." but obviously professionally you can't be friends with your clients, so most of the times, my clients will be really informal, but you have to put the barriers and those boundaries in place so that they understand that this is a purely professional relationship and that it can't go any further than that. [SA-MHP1]

Causal attributions of symptoms within the SASUs family were also found to be problematic within therapy, with a SA-MHP reporting that views held by one's family could interfere with interaction and disclosure during sessions, diminishing any progress. Engagement during therapy was also found to be influenced by service users' personal beliefs, including a fear of judgement from SA-MHPs who wore traditional clothing and fearing a breach in confidentiality.

I can only think of one client I had once and erm, erm, the client's dad - because she was quite young - didn't really believe that like, there was anything mentally wrong with her. He felt that it was more erm, superstition and more to do with like, erm, possession. So that was one South-Asian client I thought er, that the religious belief or the cultural belief was interfering with therapy. Because if your parents are not supporting you, then... the client themselves are not gonna really, er, connect with the therapist. [SA-MHP3]

I made a point of looking a stereotype Asian woman when I was practicing, really. I always wore saree. This was to challenge racism and assumption, and often young people would actually, erm, assume that they will be judged and that I will perhaps give them advice where I'd be like their mum. The challenges, for example, you know, erm, I found someone not really engaging. So when I challenged her with care: "What is going on?", this is when she opened up and said, "Because you look so traditional, I'm not sure how you'd take my issues and concerns and I will be judged." [SA-MHP2]

Erm, and there's a huge *fear of confidentiality, although erm, counsellors, psychotherapists emphasise on the confidentiality, you know? I know it's not just at the assessment session,* throughout *I will address it. Still there's a fear that someone will know about their business. [SA-MHP2]*

Another common challenge arising within therapy was the difficulty communicating due to a language barrier, which would prevent SASUs from being able to gain an understanding of therapy and its benefits. Further difficulties emerged when SA-MHPs were unable to adequately explain mental health conditions to SASUs, as they found that Western concepts of mental health could not be translated well into South-Asian languages.

Yeah, so, my very first experience was with a slightly middle aged, elderly woman. Erm, I found it, erm, a bit difficult. Erm, just- first of all, because I think their understanding of what therapy is, is... I don't think they had an understanding of what therapy was or, erm... And sometimes as well, what I found is that, that particular client, language was definitely quite difficult in therapy as well. [SA-MHP3]

… it's very, it's very erm, trying to explain what it is- depression and anxiety to someone of South-Asian- from South Asia, in their language, sometimes as well, it doesn't necessarily mean anxiety, it doesn't necessarily mean depression. [SA-MHP3]

One of the barriers I've found in therapy, is... If there's a language barrier, it's very, very difficult, and if you're not in a service where they don't pay for an interpreter, then it makes it slightly more difficult to interpret certain mental health conditions and mental health concepts in that language. [SA-MHP3]

Helpful therapeutic approaches

SA-MHPs within this group voiced the importance of catering to SASUs by tailoring therapy to their individual needs. It was widely believed by all that understanding and catering to individual differences would be most beneficial to service users' progress and produce the most positive outcomes. This included acknowledging the importance of the culture and faith of SASUs when working towards achievement of goals or progress, as they were noted to be an integral part of their identity.

Well because at the end of the day, you're trying to help individuals, erm, so you can't just go in and do what you think is right, you've got to do what's right according to the client. Because otherwise you're not going to be effective. Erm, so you are providing a service and the service should be tailored to the person that it's for. Erm, so, so that's why, really. It's putting their needs first. At the end of the day, they're the

ones who have come to you for that help, you have a responsibility to help them in the best way possible. [SA-MHP1]

The other thing is that these kinds of things; the cultural background and the faith element and everything has a huge impact on like, the recovery process of a person because it's part of their identity. So you need to know about that in order to help them, help their clients towards that recovery, really. [SA-MHP1]

For SASUs who could not speak English fluently, the provision of resources that would help increase engagement within therapy, such as an interpreter or worksheets in the SASUs home language, were found to impact the therapeutic process and overall outcome positively.

Yeah, so erm, sometimes erm, it's a handout, something like that, erm, in general, I'll try and get it in a language that they're able to read, understand. If their language is- sorry, if their English is very, very poor, erm, I would obviously get an interpreter in as well. Erm, so it's- I try and obviously cater my sessions to the individual, but if someone is not able to erm, read or write, I will probably use like, images, other things to sort of communicate that. Erm, but I always tailor all my sessions if they're SA or not. It's gets a better therapeutic outcome, yeah. [SA-MHP3]

It was also argued that traditional Western models of therapy were not always suitable for SASUs, who belonged to a non-Western culture. While the traditional Western models focused on approaches such as active listening and emphasising boundaries within the professional relationship, SA-MHPs identified that utilising such an approach may not benefit SASUs, as the euro-centric models did not take into consideration any cultural needs and differences, including the manner in which problems are disclosed and the type of relationship held with those who problems are shared with. An awareness of cultural differences prompted a SA-MHP to adapt various models of therapy into one that would best cater to the needs and difficulties of service users, such as the importance of a relationship with mutual disclosure and ability to communicate in creative ways.

> *Erm, I think there's a difference between euro-centric and ethnic-centric approaches. Euro-centric approaches would teach us erm, to be really erm, strict in boundaries. Not that ethnic-centric doesn't but it's different kind of boundaries, it's negotiated. There is, erm, flexibility, I feel. Erm, so it's about meeting different needs, meeting the needs of different people. It's what they wanted. People will have different needs and different approaches will work for them. So it really, erm, is about understanding what their expectations are, what they need, and then using that. [SA-MHP2]*

> *I change my own model of counselling. After being trained in person-centred existential, and then I done different kinds, like psychodynamic, blah blah. I found I could respect the core conditions but I couldn't totally work with the same. Then I developed my own model in saying that every person has different needs, even if they're from the same community. Erm, often, person-centred, erm, counsellors*

would believe that erm, they're there to listen respectfully, not in [a] passive way at all, but actively. But I find that sometimes some clients, if you don't actually engage in conversation, they feel that they are not being heard. And that's a huge difference, I think. So I have developed my own model, so to speak, taking bits and pieces from different er, approaches and then use it in the way that I feel that the client could benefit from. [SA-MHP2]

I used to have a client who didn't actually feel she could verbalise how she was feeling, but she was very much into, erm, Hindi music songs, okay? And I myself erm, love Indian music, Indian songs, Bollywood so to speak, and she would discuss something, er, from a film, you know. And she would sing [a] few lines from one of the songs that is relevant for what's going on with her. So you know, it's ways of erm, encouraging clients to bring out what they're actually wanting to talk about. Not necessarily, you know, what's happening erm, in terms of a story, but bringing in external information that they have, and then relating to what's happening to them. [SA-MHP2]

Changes required to improve suitability of services

Despite participants stating that they had noticed a positive change within existing mental health services over the past ten years, they clarified that services still needed improvement to be appropriate for the South Asian community. It was recommended that services should provide cultural training to mental health professionals in order to increase their cultural awareness, as it was believed that they would be better prepared to work with

service users of minority backgrounds through skills learned. SA-MHPs noted that a diverse workforce, with an increase of BME mental health professionals could also improve the suitability of services for SASUs and members of other minority groups.

> *Erm, 'cause I do think that services* do *need to change in the way that they erm, they deliver the staff training, et cetera. I do think that there's quite a lot of work that needs to be done. [SA-MHP3]*

> *I believe that any therapist can work with anybody, as long as they have the erm, commitment and understanding and respecting the culture. [SA-MHP2]*

> *And the other thing, the other thing actually, is the number of erm, people who, like from South-Asian backgrounds and other backgrounds going into these areas as well. Previously there wasn't as many whereas now you are seeing more people go into it, which will help to change the system. [SA-MHP1]*

Changes required to improve access to therapies

While SA-MHPs noticed an increase in the amount of SASUs accessing talking therapies over the years, they expressed the importance of raising awareness of mental health and making services visible within the South-Asian community. Participants stated that access to therapies could be further improved if the topic of mental health was normalised within the community, as they believed it would decrease the cultural attitudes and perceptions held towards it.

… it needs to become like... how an everyday subject, if that makes sense? So it needs to be addressed in every section of society, almost. In every kind of setting, in every kind of context, so that you can talk about it the way you want, about the weather kind of thing, to give an example. But yeah, just to make it like, so visible that it becomes a part of everyday life so that people know that this is something that does happen and it's okay to get help. [SA-MHP1]

SA-MHPs suggested that normalising mental health could be achieved through community outreach, with mental health professionals accessing and holding workshops in schools and community centres. Participants had found that holding workshops within the community allowed them to build relationships with members of society and explain mental health and services using analogies that they could relate to. This was found to increase self-referrals to the organisations that SA-MHPs were employed in.

And educating the young people, 'cause sometimes they don't have that awareness. Erm, so working with students in schools - very effective, I find. [SA-MHP2]

I remember, erm, doing a workshop. Erm, and asking where they, where they would go if they had difficulties. You know, just to explain what counselling involves. And I would use analogies from different parts of the world, you know. How people actually find emotional support and where from. So [a] lot of the participants, or my clients as well, rather, said you know, if they were in difficult situations, they'd go to their grandmother, for example. And we'd talk about, you know, what they received in

terms of sitting with someone who they could trust. And that's what I would use counselling as. You know, being able to sit somewhere and reflect on yourself and basically be able to feel comfortable in sharing your own self, er, and issues with someone you can trust. [SA-MHP2]

Participants explained that accessing the community from within allowed them to break down barriers through interaction and show members of the South-Asian community that their cultural or religious needs were acknowledged and catered to, by providing for needs that were important to them during workshops, such as prayer space and food that was suitable for their dietary requirements. It was believed that making these adjustments would display an acceptance towards their needs and help them feel comfortable enough to access services that they initially felt were strange and hard to reach.

If you've got like workshops that are running for the whole day, for example, or a few hours, again, you've got to think about those kind of things, the kind of setting you're in, is it private enough? Because obviously erm, a lot of people would actually want privacy, erm, and things like if you're providing food, is it suitable? Just the normal things you'd actually do. But I do think it's important because if they see that their needs have been catered to and you understand where they're coming from and what their needs are, then they're likely to respond to the therapy a lot better. There's nothing there threatening them, if anything, everything is welcoming them and showing that it's suitable for them and tailored for them. [SA-MHP1]

While this group heavily emphasised the importance of interacting with the community in order to make access to therapies easier, it was also mentioned that changes from a governmental level, such as an increase in funding towards mental health, could improve the visibility of services by providing mental health information in locations that were most accessed by members of the society. It was believed that making this information widely available would help change attitudes to mental health and services over time, ultimately improving access to them. Gaining an understanding of difficulties that could prevent this user group from accessing services would also allow for changes to be made to the way services were offered, including flexibility within sessions.

> *I think the government needs to think about funding, and like I say, try and make it so that it's mainstream within community settings because obviously GP's at the moment, doctors, hospitals, they're all having their funding cuts which is having a huge impact, so I think mental health services need to come out as a separate body and then have funding pumped into it so that it's existing on its own two feet, kind of thing. And then, erm, within every part of the community, every hub essentially, it needs to be there, it needs to be really visible and erm, mainstream. [SA-MHP1]*

> *Other professionals will have to be erm, more flexible. Er, every organisation, you know, in erm, ideally, in theory, have, er, some choice. Erm, some people work, so maybe there should be choice of working in the evening as well and different language needs, erm, where possible. I know that we can't make every single person happy, but as professional, we can do our best to make it accessible by*

offering them choice of language, choice of therapies, choice of erm, cultural religious therapists who would be able to erm, work with er, clients who are specifically asking for that. [SA-MHP2]

3.32 Non South-Asian Mental Health Professionals

What are the experiences of NSA-MHPs when working with SASUs?

Cultural and institutional barriers obstructing access to therapy

NSA-MHPs recognised that there were a multitude of barriers that could prevent access to therapies from within the South-Asian community. Similar to the SA-MHP group, participants in this group felt that the South Asian culture influenced the community's attitudes towards help-seeking due to the stigma attached to mental health and disclosure of personal issues to outsiders. Participants noted that personal issues were expected to be kept to oneself or within their family, as there was a fear of being judged by the wider community. This often meant that gender role expectations were enforced within the family, to reduce the risk of shame. It was also acknowledged that the community was often interlocked with the identity of those belonging to it, which caused internal conflict for individuals who wished to speak out, as disclosure would risk ostracisation. However, while seeking external sources of help was not socially acceptable within the community, it was found that services would be accessed as a last resort.

So yeah, it goes back to the attitude with relationship to help; some of them are more receptive of it and some of them are not receptive of it and I guess it's a culture thing. [NSA-MHP8]

Two very important things. One is about the stigma around mental illness. So, to be saying that you have mental health needs means you have to take on the stigma and it's very very difficult for a lot of people to take on that stigma. And the other thing is to be seeking help. That is another stigma. So to be seeking help for mental health means you've got a double whammy of stigma to deal with. [NSA-MHP6]

There is *a stigma attached to mental health. Erm, and you keep it in the family. And fear of it getting out, fear of other people knowing because it is about what the people are gonna say. [NSA-MHP4]*

South Asians- their identity is attached to their culture sometimes, is attached to their conflict with their culture. Yeah, it's very much attached to erm, collective erm, group, collective community. So, you are identified within the community. Your identity is in *the community. And erm, so the example would be er, let's say a woman is going through er, domestic violence. Or erm, a gentleman is a homosexual. There may be this conflict of like, "I can't leave." because their identity is* attached *to their family. Their identity is* attached *to their community, and without that, "I'm no one. I'm nothing. I've got nothing." That's too much to lose. [NSA-MHP4]*

And the interesting experience of actually feeling, 'Wait a minute, when it's that *severe, actually people do accept, the family accepts that they cannot cope.' Whereas anything less than that level of crisis, maybe you tried to sort it out in the family, sort it out in the wider extended family or community. [NSA-MHP7]*

This group also held the belief that cultural views of the community and family towards mental health and individuals who suffer from it ultimately impacted an individual's decision to access services. As well as fears of backlash from the community, it was also feared that if external help was sought, professionals would not be able to understand their difficulties. However, accessing a professional who shared their cultural background was also very rarely an option, as it was feared that professionals from the same community may know an individual's family and would breach confidentiality.

Erm, another kind of important factor in my mind is erm, shall we say the stigma that is attached to the general idea of that somebody got mental health problem. That seems to be kind of having a great influence on the way that they might be proceeding with the problem or they want to access support. So, very much is depending on the social network; how they're perceiving stigma as well as how the individual perceives the stigma of mental health. [NSA-MHP1]

Er, sometimes they may think they will not be understood well. [NSA-MHP5]

There's also that fear of "If, erm, I go with someone who understands the language, will they know my family?" Or, "Will it get out?" So, they may not want to do that. [NSA-MHP4]

If external help was sought, most individuals would initially access their GP, but participants voiced their concern at the lack of referrals from within primary care. NSA-MHPs stated that SASUs in therapy often complained of their experience seeking help for mental

health issues from their GP, as they were commonly known to prescribe medicine instead of referring individuals to mental health professionals. It was noted that South-Asian GPs, especially, would not refer due to holding traditional cultural views towards disclosure to outsiders, which impacted the well-being of those who sought services.

> *And erm, another example I can get is erm, one of them who has some tablets for his depression, erm, he's feeling that he's getting better and then he went to the GP and then his doctors- what he tell me, was the experience was not all good. And he told me, because he think they were not serious and they telling him "Do some sports." and things like that. "Reduce the medicine and [at] the end, don't take it." [NSA-MHP5]*

> *Erm, even some GP services don't even erm, refer. They'd rather give them the medication and say "Off you go." [NSA-MHP4]*

> *I did have a real concern about the idea that there* was *the GP referral problem, that I think some of the GP's - and I think it was some of the South-Asian GP's who were* extremely- *they weren't enthusiastic about psychiatry, period. You know, and I think they did feel there were cultural shame issues in someone having to come for these services. I think they'd much more happily prescribe anti-depressants, erm, and say "You've got depression." even when that's pretty implausible. But I don't have any concrete evidence to that. [NSA-MHP7]*

Participants also verbalised their displeasure at public health services, which they felt did not do enough to cater to the South-Asian population in England. While NSA-MHPs were aware that mental health services did in fact exist, it was argued that they provided a limited, generalised service using a one-size-fits-all approach. Participants claimed that this approach was not suitable for the South-Asian community, as it did not focus on understanding cultural differences that could hinder progress within limited sessions, such as BME communities needing space to think before openly verbalising problems. While this was the view of most participants, one NSA-MHP felt that services were equally accessible for all and that the South-Asian community would not have any difficulty in seeking or accessing these services.

I mean for- in [town], at present, I know it is a lot more, erm, but in the last census- UK- the population percentage-wise was- 37% of the population erm, is of Asian origin. Of that, as you can imagine, the majority would be Muslim Asians of Pakistani, Bangladeshi origin. Erm, and in 2000-what? 2011...'12, they commissioned services from us for 20 people a year. Twenty! Out of 37% of [town'] population. We're talking about more than 200,000 people and just imagine for- even if you were to just simply pretend there were 25,000 Asian people in [town], twenty people in a year?! It's a joke, as far as I'm concerned. [NSA-MHP6]

Erm, it's very generic, the er, therapies that are out there. It's not tailored to the needs of the erm, client. So if a, you know, if you go for, you know, a CBT, six sessions is very structured and you know, you go away and you do the homework and there isn't an

understanding of the client and their specific issues. It's just like you know, slightly robotic. Like you know, if you've got anxiety, "Try and do some breathing." you know, sort of thing. [NSA-MHP4]

I don't think it's accessible. Erm, it's not really considered as a major concern. Er, it's not like they feel that it's, you know, it's something greatly needed and needs to be specific for South-Asians to be accessing it. It's just "Here you go. If you take it, you take it. If you don't, you don't." [NSA-MHP4]

They need to take into account context. Because not every... not every problem can be fixed in six sessions! And for certain communities, they need to learn to think about their problems before they can talk about their problems. And the majority of people from black and ethnic minority communities would *need to think through before they can use counselling. [NSA-MHP6]*

I think that all the mental health services are available for them, IAPTS are always accepting self-referrals so they can self-refer online or on the phone, so I don't think that there would be any difficulty for them to find health services. [NSA-MHP3]

While participants noticed that conversations regarding the need for change within services took place, they felt that professionals and organisations did very little else to implement those changes and did not understand the reasoning behind lack of access from

the South-Asian and other minority communities, as availability was thought to be equal to accessibility.

> *Erm, yeah, I suppose I feel we've made remarkably little adaptation. We've given remarkably little thought in- a larger part of the UK is now such an obviously, multicultural multi-ethnic society. We've paid a lot of lip service to that and done very little for it. My blunt view. [NSA-MHP7]*

> *And if you were to talk to mental health service providers, what I hear consistently is, "Oh well, even when we provide services, they don't use it, they never come, they don't use it." And it's like, well, the way you set it up makes it impossible for people to access services. [NSA-MHP6]*

Mental health professionals' preconceptions

Participants within this group also acknowledged preconceived notions as detrimental to service users' progress within therapy. While most NSA-MHPs expressed their awareness of stereotypes and assumptions held towards the South-Asian community, it was apparent that this was not the case for all participants, or colleagues of participants. Those who were aware that there was a possibility of their thoughts towards the South-Asian community deriving from prejudice actively worked on improving their knowledge to reduce this risk. They were also able to identify where their discomfort developed from, noting lack of cultural awareness as a reason and explaining that their discomfort reduced once they openly accepted SASUs and began working with them. In some instances, however, it was

apparent that personal thoughts towards the faith of a SASU could impact the way mental health professionals viewed them, with one NSA-MHP attributing lack of freedom in female SASUs to their religion, and another presuming that the faith and academic choice of a male SASU would result in terrorism.

> *Apart from that though, it's interesting because before I actually got so, like, engaging in erm, this culture, there- I must admit, that there was some amount of reservation, erm, because of lack of ignorance- like, ignorance, rather. Lack of knowledge, not understanding, "Do these people actually think like me, or?" Yeah, "What will they think about me?" Like, even wearing this, or do, you know, that kind of stuff. Erm, and that's my own barriers. And I had to overcome all of that to just be, erm, real enough and open enough to accept another culture for who they are and then, "Oh my God! You're like, really cool!" So, yeah. [NSA-MHP2]*

> *I found that it can be maybe from the religion. Muslim women were more, they had less freedom to choose what they wanted, and they were quite subjugated in their relationships. Their freedom was more difficult. [NSA-MHP3]*

> *This is a colleague with twenty years of experience of providing therapy, met up in supervision and she said erm, "Guess what guys?" What? She said, "I had this erm, young Muslim guy from Cambridge, he's a Cambridge student, really brilliant. And he was telling me about his studies." Whatever whatever. "As soon as he mentioned one of his subjects being chemistry," she said, "I freaked out." It just didn't occur to me so I said, what happened? She said, "Him. Muslim. Doing Chemistry." I said, what? "Don't*

you get it? Muslim? Doing Chemistry?" I was like... is that what you think?! So the immediate assumption was that if he- it doesn't matter what else, what other courses he's doing, but the assumption that just because he's doing chemistry, he's going to create a bomb and you know, he's going to be involved in an explosion. And she genuinely said she doesn't want to work with him, "Is there anyone who would be willing to work with him?" It was so tragic! I am sure she would never tell him "Because I'm worried that you might be a terrorist even if you're not a terrorist now*, someday in the future you might be a terrorist." She would not say that to him, but she would find an excuse of pushing him on to another person. And I just find things like that really, really terrible. Really terrible. [NSA-MHP6]*

Awareness of cultural differences arising in therapy

Most NSA-MHPs, having worked with both the South-Asian and Non-South Asian communities, reported that they were aware of various differences in therapy that were related to the cultural beliefs and values of SASUs. One of the common differences was the way in which SASUs and non-SASUs would communicate about their difficulties. It was found that SASUs would relate their issues to problems within the family or community, and causal attributions towards mental health, such as black magic, while non-SASUs disclosure was related to personal difficulties such as bullying and bereavement. It was also common for the SASUs to describe their difficulties using somatic language and having less of an understanding towards ethical boundaries within a professional relationship, which did not seem to be a problem with non-SASUs.

The differences are the problems that they may come up with. Some of them are similar, but some of them are different. So with South-Asians, there is, you know, issues of erm, black magic - that's mentioned quite a bit. Erm, complying to in-laws, erm, and their- their expectations. Erm, it's very much to do with, erm, the community. To do with, er, the parents and their expectations and there's kind of a lot of pressure and that's why I mentioned relational aggression. It's very much, sometimes, to do with breakdown in families, Yes, so with the non-SA community, it's not really much to do with that- *the cultural issues. It's much to do with erm, bullying. They were bullied at school and they've developed erm, a disorder, or they've been recently diagnosed with a disorder, erm, in that trauma of one occasion, say like, rape. Erm, what else is there? Er, a death of a family member, a close family members. Erm, social anxiety because of ill health and not being able to get out of the house. So it was kind of very much more* single *problems, whereas with the South Asian, it was extremely* complex *problems attached to each one, if that makes sense. [NSA-MHP4]*

Erm, and a lot of, very crudely speaking, somatic components to, to what was going on. A lot of concern about digestion, about breathing. [NSA-MHP7]

There were also apparent differences within the SASUs, with NSA-MHPs mentioning gender and generational differences. Participants noticed that there was a tendency for male SASUs to display an attitude of strength and manliness in sessions, while women tended to be more reserved. This was not the case for all participants, however, with some stating that women had no difficulty when disclosing.

I felt that, like, there were certain things within like, religion, culture, that you know like, particularly women are expected to behave a certain way, and erm, to be sort of, not voice so much, their opinions and you know, so I get that sense whenever, because I've, I have worked with both females and males, erm, I found that the females erm, are a bit more reserved, yeah. The males on the other hand, are slightly different. So the males were, some amount of reservation but they were more willing to, to disclose, you know, like erm, sort of had this- more of a ownership of what they were doing and what they wanted and kind of 'the boss' kind of an attitude, from the males, yeah. [NSA-MHP2]

Asian ladies have, you know, they have to keep their face, you know, kind of, walls from outside but in the therapy room they were like everyone else and they could open up… sometimes they feel like they have to keep erm, one image for outside and they have more engaged within the therapy room and they have trust and they can open up. [NSA-MHP3]

Differences between the younger and elder generation were also noticed. Participants found that they had different views towards accessing services, with the elder generation perceiving it as unhelpful and finding it difficult to disclose personal problems, while the younger generation had a greater understanding of the system, and therefore accessed them with a positive attitude, often being able to pinpoint what they wanted to gain from therapy and disclosing with less difficulty. It was also noted that the problems disclosed by the elder generation were often linked to changes that would affect their identity, such as the inability to continue providing for one's family and therefore no longer

being the breadwinner that they had been for a large portion of their lives. The differences between the generations was considered to stem from their attachment to cultural beliefs and values and influenced the type of problems that arose in therapy.

> *… they were hitting the kind of end of their working life, it was certainly in UK, you know, expectations. They were hitting retirement age and they were probably, I suspect, finding it much harder to get some jobs. It didn't, it felt like there was this massive, massive loss of status, that you weren't the breadwinner in the way that you were. I think for some of them, there were younger generations who were now getting much better paid jobs. I felt there was huge fear, often, about feeling caught, almost wondering whether to go home, because I think for most of them, home really wasn't the UK, even though they might have been here for 30 years, or something like that. [NSA-MHP7]*

> *Mainly, the main thing is, if the people know that this therapy is helping them, they will come. So I think the young people, they know. The young generation, they know, they can come. They know the language, they can feel free to talk about their emotions and things like that, and they are okay. Mainly there are middle aged and older generation, that's the one who might be- that's what I thinking- maybe don't like to tell their problems to strangers? Maybe they don't like, erm, they don't think they will get anything from it, things like that. [NSA-MHP5]*

Challenges arising in therapy

Participants also identifies various difficulties that arose in sessions, often stemming from the SASUs cultural or religious beliefs. One of the common challenges described by NSA-MHPs was related to disclosure. It was found that SASUs were less likely to disclose issues of a personal nature, regardless of whether the mental health professional shared a similar background to them or not. Participants explained that they often had to emphasise confidentiality and safety throughout the therapeutic alliance in order for the SASU to feel comfortable enough to begin disclosing openly.

> *First and foremost is that whether they feel okay to share information. So, feeling safe to share the information, that primarily seems to be the part of it. And the other one is whether they're feeling okay to share with other people. [NSA-MHP1]*

> *Like, as much as I actually say, "This is your space.", "This is your time.", "This is just for* you*.", you know, "Nothing that's been said here is gonna be transferred outside.", do you know what I mean? So even with that, it took a while to really develop that, that trust. [NSA-MHP2]*

Female participants also reported that it was common for male SASUs to display challenging behaviour in therapy, often not being open to suggestions for improvement and pushing boundaries by wanting to communicate outside of the agreed arrangement. Participants stated that firm cultural beliefs held by males would often make it challenging to progress through therapy as SASUs found it difficult to detach themselves from cultural norms.

Erm, South-Asian men, I tended to find, erm, more challenging. Erm, they particularly or generally wanted face to face [therapy]. Erm, I just got a... a sense from the way they were speaking and the way they were driving the conversation, about wanting it to be face to face, was to do with because I was a woman, erm, that they wanted to see erm, me, as opposed to be really focused on the erm, the counselling. So I've had a few of those. Erm, and I've had a few who have been absolutely fine, have worked on their, their difficulty. [NSA-MHP4]

I would say the most would be working with men, particularly Asian Muslim men. Erm, possibly because of the way they have been brought up; they don't like being challenged by a woman, even if they can see the sense in being challenged. Their immediate reaction is "Whoo!", so you could hear the voice raising and the defensiveness and you need to point that out and you need to work with that. [NSA-MHP6]

… they are not wanting to be taught. Particularly the fathers, actually. I realised that the mothers were very receptive. But the fathers would... challenge or would have a set idea and that's the one they want to go with, so it took a while and a lot of different examples or erm, I don't know, I guess patience as well, until you see, like, there is some sort of understanding. [NSA-MHP8]

It was also noted that it was common for SASUs to expect their therapist to provide solutions to their problems, instead of working alongside the therapist to discover solutions themselves, as is the norm in Western therapy. This was combatted by compromising

between the service user's expectations and the traditional approach to finding solutions, which was found to have a positive effect on the service user.

> *They expect you to have the knowledge and they expect you to kind of tell them what- what the best thing for them, which kind of mismatches with this style of therapies that's being offered in the Western society, which is very much of a neutral position and we find our own way together. Whereas in South Asia, the expectation is, well, you might be wearing a white coat or you might not, but doesn't matter, you tell me what's wrong. And to adjust that, you need to work a little bit to kind of come to form of compromise. [NSA-MHP1]*

Another common challenge that arose in therapy was the use of an interpreter. While it was acknowledged that SASUs with limited English may not be able to access therapy without one, a number of participants felt they were not suitable in providing adequate therapy as the language barrier between the therapist and service user resulted in words being lost in translation. There was also the concern that interpreters could have a negative effect on the service user's progress if their views did not align with the therapist's, and that not being able to engage with the service user directly could cause feelings of disconnect.

> *I know one of our clients, English was so limited, so another lady was here, although she was our team, and she was translating and I'm sure, through the translation, something was lost. Because you never translate feelings and things like that, and what the person really says, in any language. [NSA-MHP5]*

Yet the translator might have got their own agendas and their own kind of reservations, or their own kind of ideas that they might be influencing. [NSA-MHP1]

But I think because we had that middle man, it was very much, "Okay, now I have to wait until she explained whatever she had to explain", and then, erm, the father would say whatever he wanted to say and she would respond to that and she would come back to me. So I felt a bit disconnected, I think that's the word I am looking for. [NSA-MHP8]

While it wasn't frequently discussed, one NSA-MHP identified challenges relating to keeping female SASUs in therapy. It was believed that male relatives of female SASUs would decide who they could speak to and what could be spoken about, which often resulted in female SASUs not being able, or allowed, to continue their sessions.

I had only one kind of problem in keeping young ladies in therapy. That was the aggression of their male partner, or the aggressive behaviour of their father. So, they were kind of not permitted to attend therapies or to talk about family problems there. So, it was a kind of pressure or aggressive behaviour from male family members. [NSA-MHP3]

For participants who conducted therapy with families, it was revealed that there was often a culture clash between parents who immigrated into the UK, and their children, who were born or brought up here. This would result in conflict between the parent and child, as

the differences in societal and cultural values were difficult to accept for parents who expected their children to abide by traditional norms, such as showing complete obedience to the father.

> *… so whenever the children, especially those who are born in the UK- so they have the different culture backgrounds, when they grow up in this society how we have our social values here- when some of the parents who were born back home, they find it challenging and that's what- when I realised, okay, now there's a culture clash within the family, because you have the traditional Indian parents and then you have the son or daughter who was brought up in the UK and what's important to them. Their values were based on their surroundings, what their friends say and so on. [NSA-MHP8]*

Helpful therapeutic approaches

Having an awareness of the needs and difficulties of the South-Asian community allowed the NSA-MHPs to understand how the therapeutic process could be altered to benefit SASUs the most. Participants in this group emphasised that catering to service users' individual needs would result in a much more positive outcome. It was stated that this could be achieved by learning about an individual's background, gaining cultural understanding, and giving them some control in how they would prefer to be helped. NSA-MHPs stated that it was imperative for the therapist to be open towards discussing topics that were of importance to the service user, such as their faith and culture.

Because there is, there definitely is something that you have to, you have to adjust. Understanding the person, where they come from, and you have to share some of your ideas, about sort of, what might be an experience for you. It's more like, kind of, it allows them to examine you as well as you examining their experiences, so, it's much more of a neutral ground. [NSA-MHP1]

You have to be patient and ask what they want or their- how they want to be helped and things like that. And that's what I think everybody could do to help. [NSA-MHP5]

So if you realise that, erm, religion is important for the person, to acknowledge it and have the discussion around religion instead of erm, maybe pushing it to the back. Or if health is important for the person, to discuss about it within the session. [NSA-MHP8]

A lot of people, what they're talking about- their issue, and religion's there. Their religion is main; either praying or either patience, or things that the culture or the religious things that the people do when they have difficulties. That's the main thing. The main thing they have is their culture or their religion, and you have to emphasise that one. But if the main thing the person talk about or their fall-back things are religion and culture, you have to be open to that and talk about that and let the person know that you are okay with talking about that issues. [NSA-MHP5]

Participants found that the ability to understand difficulties that could arise from SASUs culture enabled rapport to be built, as service users were able to witness an effort

being made to understand them. It was also mentioned that being respectful of culturally-appropriate forms of greeting was well-received.

> *Erm, if you er, really understood erm, specific cultural issues that they were talking about and you could really relate to that and you really reflected on that, back on that, then instantly, you would get a rapport with that individual. Because you're then, they can see that you're trying, they can see that you understand. [NSA-MHP4]*

> *It was another patient I'd seen in that service, she came through to my group and I, in the way I very often do, I put my hand out to shake hands and she said, "I'm sorry, I don't shake hands." I thought, "Oh God, yeah, I know that, don't I?" If I'd thought for a minute, I'd probably guess that. [NSA-MHP7]*

> *Erm, if I'm meeting an older person, I probably- even older than me - I would say 60 upwards, erm, I probably almost bow, very slightly. Erm, and I probably- sufficiently for it to be quite visible. And I think for some people, you know, it is a little bow. Now bowing is not part of my cultural background, handshakes are. Erm, and I think that probably matters, I've had the impression that that kind of- and it feels like a way of indicating that I respect the age, erm, and within the kind of cultural convention. [NSA-MHP7]*

It was also observed that adopting the service user's use of language enabled concepts to be explained in a way that they could understand, which had a positive outcome on the service user's progress as well as within the therapeutic alliance.

I think within the Asian community, because the terminology might not even exist. If you were to describe it, people can relate to it but if you were to simply say "Depression, schizophrenia, anxiety" whatever, they wouldn't know. They cannot relate to the concept. So part of what is necessary is when you are communicating to people from Asian, erm, South-Asian background, you need to be talking about the symptoms and the behaviours, not the diagnosis. Because they cannot relate to that. [NSA-MHP6]

And the thing that really stuck in my mind was that I sort of discovered that I was invertedly using very somatic language. Erm, yeah, I was saying "So you're getting very fed up with that?", "You're getting very choked up about that.", or "That's really sticky in your throat, isn't it?" Erm, and it wasn't deliberate. I mean, it was me who suddenly realised I was doing it, but I also realised, it seemed very clear to me, that it was working. [NSA-MHP7]

Participants found that being flexible to the needs of SASUs resulted in increased access to services, as issues that would initially prevent individuals from accessing were worked with to make services more suitable for them. For example, this included allowing service users to attend therapy with people they felt comfortable with, making adjustments to the time of sessions if needed and offering services to service users' family members. It was also beneficial to understand the importance and influence of family within the therapeutic process, as well as traditional routes of help-seeking. For example, one NSA-MHP was able to gain an understanding of how different Western routes of help may seem to South-Asians by taking part in a traditional form of healing.

When I was working in a college and there were lots and lots of 16 years olds, they want to come with their friend. So I would say to them, you know, my counselling room is tiny. It was smaller than this one, they'd be sitting two by two, and you know, because the friend is not going to be able to say anything unless someone is holding his hand or her hand and it's like, well, if that is what will get them through the door, if that is what will allow them to do the talking, by forcing them not *to, the only thing I'll be creating is a barrier for self expression. Erm, most of the time, they would say well you know, can I come with my mother? I'm talking about when, you know, you have an older client, a son, a daughter might want to come. And you know, at the beginning I would simply say- initially, I would say, do whatever would make you feel free and safe. Because until they get to know me, I don't assume that they have to feel safe with me. But once they have achieved a degree of safety, I would rather whoever is waiting to wait outside so that the client would be with me and learn to deal with their problem on their own. Erm, so that is, you know, an adjustment. One adjustment that would be. Another is time, because erm, therapy, when it comes to therapy, the tradition is that you have to use, kind of, if is it Wednesday, half past two, it has to be Wednesday half past two* endlessly *until therapy relationship ends. My experience is a lot of people's lives do not work like that. They have hospital appointments, clients fall ill, weddings, whatever whatever. Instead of making it difficult for them by insisting, unless they make it at half past on a Wednesday and they have to prioritise counselling and give up on everything else, I would be willing to make reasonable changes to the time. Not necessarily going all over the place, but reasonable changes. If from time to time, they do have problems, I'll be willing to change the time of the session. [NSA-MHP6]*

And I participated in an exorcism; they were erm, Muslim Pakistani, I think, pretty sure Pakistani background parents… Erm, and although the parents were very clear that she was safer with us than with them, they were also very clear that she should have the privilege of an exorcism and they bought what I call, an exorciser - I don't think he was an Imam. And that sort of gave me a real insight into just how alien what we were doing must have seemed if that didn't seem alien. Because you know, writing things on plates and washing them off, which was part of the process felt incredibly alien. And I thought, well, I'm going to tip it the other way around. So what we're doing doling out drugs and so on, must feel pretty weird. [NSA-MHP7]

While it is clear that most participants used various approaches to build rapport and tailor services to the needs of those accessing, one NSA-MHP explained that adjustments based on the cultural background of service users were not made in therapy, as the organisation were committed to offering a service that adhered to equality and diversity guidelines, focusing on treating all service users equally.

They didn't receive any special adjustments. Like any cultural thing... I think because the institute I worked for, they were committed to equality and diversity, so I think it would have been just strange to give special adjustments for South Asians, or they didn't- we didn't make special adjustments for Africans or any other minorities. So we tried to keep the service equally usable... I think it's a common rule in the mental health services. And if they have some special needs like learning disabilities or something else which needs more adjustment during therapy, then mental health

services would provide those adjustments for them or use adapted tools for those mental health problems but I think that based on the culture, they don't have any special- but they have the same access to therapies as others. [NSA-MHP3]

Changes required to improve suitability of services

NSA-MHPs firmly believed that existing mental health services needed to change in order to become appropriate for the needs of the South-Asian community. It was recommended for existing services to provide cultural awareness training to professionals so that they're better suited to interacting and helping people from BME communities. It was also suggested that existing services providing culture-specific facilities for the BME community would result in positive outcomes, as it was important for service users to feel understood by those they were disclosing to. Participants believed it was important for existing services to invest in BME mental health professionals as communities being aware of professionals who shared a common background and language may decrease the hesitancy in accessing services that are otherwise thought to be unapproachable.

For you to be able to connect with them, to understand them, er, you need to then have some form of awareness. Either through you know, your own research and studying or getting to deeply understand the client in the session and holding that. Erm, but if you're talking about general health professionals, then it is about training and being that- having that awareness. [NSA-MHP4]

Erm, it's great. I mean, the more niches that we have, erm, the better. The more services there are out there, the better. Erm, because it is a very multicultural society

and more and more complex erm, and it's great to have a South-Asian counselling service like that. It's great to have an Islamic counselling service like [organisation], and there needs to be more niches out there because you know, there's a potential of having one that's just specifically for erm, say, the African or erm, er, Middle Eastern er communities, because they come with different issues. Yeah, and it's very complex. And if you have a specialty in that, then your results are gonna be a lot more better. Because I've- the great thing is that the results that we get from the South Asians that I've had is good*, and it's because we have a common understanding. And without that, sometimes without that common understanding, erm, they don't feel understood, they don't feel heard. So then the progress of the therapy is limited. Yeah, erm, so it's great that it's there but I also think that it'd be great to have others. [NSA-MHP4]*

I think if there is erm, a genuine commitment to provide services, mental health services to people from Black and minority ethnic communities, a genuine *commitment, I would say it should start with training people from these communities so that they* could *be the champions and service deliverers. So if there is any commitment to equality of access to mental health services, the NHS should invest. [NSA-MHP6]*

NSA-MHPs emphasised building links with the South-Asian and other BME communities through respected individuals such as community and faith leaders, who could influence and encourage the community to access services. It was also noted that services

should prioritise access by providing therapies when they are sought instead of having to wait before they can be made available.

> *I think the lack of accessibility again seems to be the key problem, and also the other part of it was that the erm, opportunities. Like, for example, the imams and the other kind of religious kind of leaders, whether they are, I dunno, priest or otherwise, any of them have got the potential to encourage the other general public to access services, should they notice anything or should somebody confide in them in some way or another. [NSA-MHP1]*

> *I know there's help and at the* end *they will get help, but sometimes the process can be easier and can be direct and can be, and the person can be helped, and it will be less help needed if the first process is improved. So I think the waiting, going first GP, taking some tests maybe blood test or something and then wait, and then I think, through that long process, it'll be easier if there is something come quickly, check the people when they need it at the first step, and it will be better than waiting and the process is longer. The people will get help at the end, but it will be better for the people and better for the NHS and everybody, if the process can move quickly. [NSA-MHP5]*

Changes required to improve access to talking therapies

NSA-MHPs expressed the need for existing mental health providers to engage in community outreach in order to raise awareness and educate communities about mental health and services available. It was believed that community hubs had some influence over

the decisions made by community members more so than mental health professionals would, but they often held traditional cultural views towards seeking external help. For this reason, it was recommended that community hubs should be educated prior to accessing the wider community, in order for them to encourage service use from community members. It was also noted that raising awareness in schools not only educated and normalised mental health for children, but also provided access to their parents, who could choose to attend workshops at their child's school during the day.

> *I think that they need to be educated as well. They hold the same sort of views about counselling and mental health services. Erm, they don't understand the system, they don't understand how it could be supportive. They may relate it to black magic, so it's like, you know, what they- they want it to be kept hidden. Erm, so yeah, they first need to be educated and it might be worth giving them like, sort of training and awareness themselves first. [NSA-MHP4]*

> *…and we used to go to schools and the mothers used to come there when the children are in the schools. And mainly, it's either afternoons or sometimes in the mornings. When I went there, they were there ready to talk and because the session was about improving their erm, mental wellbeing, mainly how to reduce stress, how to reduce erm, when you're anxious, when you do things like that. Erm, and whatever we were giving them, away they took and because a lot of them, stresses we have are human; it's from the family related, things like that. At the beginning, my assumption was because they know each other in the same school and something like that, it could not be erm, not so much productive. But that was not true! At the end, some of the*

sessions we continued after 12 weeks. "Can we continue?" and it was useful and they did well. [NSA-MHP5]

It was also noted that different generations could not be approached in the same way, and that they needed to be accessed using different techniques. For example, NSA-MHPs found that the South-Asian elder generation did not usually pay heed to suggestions made by the younger generation, instead listening and taking advice from those they held in high esteem, such as faith leaders. The younger generation, however, could be accessed through social media and places of social gathering. Participants explained that having an understanding of how best to reach different generations and making the effort to do so could possibly increase access.

Erm, so you've got obviously different generations, so if you're-you're targeting the older generation who, erm, weren't *born here, who are from- you know, from their own home country, you're targeting* them*, then you know, the way you approach them is very different. It might be the case that you need to liaise more with the erm, say their community hubs. So it might be their places of worship where you would involve the, er, leader from that community. So it could be you know, the Sikh temple or it could be at the masj- at the mosque. Or other places where they reside and gather. And you bring awareness through those that they respect, because it is about looking- looking at the one in the community that they respect as opposed to someone who is younger, er, they may not take it from them. So if they hear it enough and often enough by those who are in the community about the benefits of counselling and dispel those misconceptions about counselling, erm, then maybe they*

would access it more and knowing what the services are out there because a lot of the times they don't*. Erm, if you're looking at the younger generation, then it could be about through social media. Erm, because that's where they kind of sort of gather. That's their style of meeting up. But they also meet up in the community hubs as well, you can kill two stones- er, two birds with one stone in that way as well. [NSA-MHP4]*

Chapter 4. Discussion

The purpose of this study was to gain a deeper understanding into the experiences of British South-Asians when accessing talking therapies and to answer the research question, *"Are talking therapies culturally relevant for the British South Asian Community?"*.

In order to answer this question, a qualitative methodology was used to interview three different groups – South-Asian service users, South-Asian community members, and mental health professionals; who were split into two sub-groups consisting of South-Asian mental health professionals and non South-Asian mental health professionals. Findings from these interviews revealed a number of themes.

It was found that South-Asian service users had a limited awareness of the therapeutic process which led to initial feelings of apprehension when accessing services; that disclosing personal difficulties to those outside of their community could be problematic and reflect badly on their family; and that the behaviour and commitment of their therapist positively influenced their relationship. While this was apparent for most, it was also reported that the therapist could become an obstacle to progress if there were differences that made disclosure difficult, such as a lack of cultural awareness and differences in gender. The South-Asian community group felt that there was an inability to acknowledge symptoms as mental health conditions from within the wider community; that openly expressing emotional or psychological distress was not accepted and that there was a general view of public services lacking cultural understanding. It was also found that the traditional views held by the community could change if they were educated about mental health services and its benefits. Finally, both sub-groups of mental health professionals acknowledged that there were a variety of issues that could obstruct the South-Asian

community's access to services and recognised that challenges within therapy were often related to the cultural beliefs of service users. Through their many years of experience, most mental health professionals were aware of techniques and approaches that would be most beneficial to SASUs progress and believed that vital changes needed to be made for services to be considered appropriately suitable and accessible for the South-Asian community.

Most SASUs shared that they had positive experiences of talking therapy. This finding contrasted with previous research, which stated that existing MHS were not suitable for members of the South-Asian and other BME communities (Bowl, 2007). However, upon further questioning, it became apparent that positivity towards services received were highly dependent on cultural understanding within the therapeutic alliance. Those who reported that therapy was beneficial explained that their therapists would display an active interest in understanding their background and culture. On occasions where SASUs were not understood, therapists would attempt to increase their awareness, which had a positive impact on the therapeutic alliance. This was corroborated by Rathod et al. (2010), who found that cultural awareness and understanding was most beneficial in producing successful outcomes in therapy with service users from BME backgrounds.

There were also occasions when SASUs felt their progress within therapy was hindered. This was most apparent when little to no cultural understanding was displayed. One participant in particular linked the lack of cultural understanding to the gender and ethnicity of the therapist, suggesting that opening up to the therapist would be a waste of time, as they believed they would not be understood. However, this was not the consensus amongst the SASU group. Being understood was more important than the therapist being of

a specific gender or ethnicity. It is also possible that the rest of the group had therapists who displayed understanding, so similar issues did not arise for them.

While many MHPs from both sub-groups reported that there was a significant need for cultural understanding and adjustments within the therapeutic alliance, this view was not taken by all. One NSA-MHP stated that it would be strange to make cultural adjustments for service users of any background, as the service providers firmly believed in offering an equal service for all. This view is not uncommon, with Patterson (2004) arguing that cultural competence for clients that are not part of the majority population are unnecessary, as talking therapy can be universal. While this was only expressed in one interview, it highlights that there is not unanimity in the belief that culturally adapted therapies are beneficial. This deviation from the norm, while egalitarian, does not acknowledge the influences of culture on an individual's beliefs and actions. Such an approach was found to build a barrier to access, with both SASU and SACM groups highlighting that this could result in a refusal to re-access the service.

Previous research has also stated that the suitability of services could be improved through a diverse workforce (Smith, 2009), with SA- and NSA-MHPs similarly holding the belief that an increase in professionals from the South-Asian community could benefit and allow cultural needs to be understood. SA-MHPs also believed that they would be most suitable to engage with SASUs, as the shared background enabled them to understand service users in a way that NSA-MHPs could not. Interestingly, service users were hesitant when asked if they would prefer a therapist of their own ethnicity. There appeared to be a general mistrust of South-Asian therapists, due to the belief that South-Asians would judge the service user for their actions and breach confidentiality by discussing a client's issues

with others from their community. The ideal therapist was suggested to be a non-South Asian from a BME group, who understood the family dynamics and behaviours of collectivist cultures. This lack of trust in South Asian therapists needs to be explored further, to better understand the causes and identify how it may be improved. The aversion to accessing MHPs from the same ethnic or cultural background was also corroborated by Ahmed-Stout & Nath (2013). While it may be useful for services to invest in BME mental health professionals for those who do wish to access them, the belief that they would be better suited for the needs of minority ethnic individuals does not take into account that identifying with an ethnic or cultural background does not guarantee an understanding of it.

In addition to this, a number of cultural idiosyncrasies were mentioned by most SA- and NSA-MHPs, and an understanding of these may help aid successful therapy with SASUs. These included the expectations of SASUs towards their therapists. A number of MHPs stated that SASUs were often unable to understand the boundaries of the client-practitioner relationship, resulting in the need to educate service users of its importance. While this was not found in existing research, the expectation of creating a friendship with the therapist may be related to the way in which issues are typically solved within the South-Asian community. The cultural attitude of seeking help through immediate family or close relations may result in SASUs needing to create a similar bond with the therapist in order to disclose difficulties easily. This was seen with one SASU in particular who likened the therapist to a friend with whom a mutual relationship could be built.

Other expectations commonly arising within therapy included the expectation of the therapist providing solutions to difficulties faced. There is a possibility that this could be linked to cultural beliefs held towards those from whom help is usually sought. Within the

family, for example, these may be respected elders, who may offer guidance and direction (Sung, 2001). As this is common within their home environments, it may also be expected from those they view as authority figures outside of the home. Another explanation for this may relate to views held towards healthcare professionals that are commonly sought, such as GPs. A lack of understanding towards the differences between healthcare professionals may lead to service users expecting to receive help in the way they are typically used to.

Cultural gender expectations were also noticed in therapy, with NSA-MHPs reporting challenging behaviour and displays of strength from male SASUs. The expectations of South-Asian men to display strength was identified in previous research (Hwang et al., 2008). Ingrained gender roles combined with the belief of disclosure being a sign of weakness may have resulted in the challenging behaviour seen from male SASUs in therapy, in efforts to prevent being perceived as anything less than strong. This was also mentioned within the SACM group, which highlighted the role of men as providers of the family within the culture, with an emphasis placed on strength in order to adequately fulfil those roles. On the other hand, women were either thought to be involved in the therapeutic process, or reserved. Reservation within therapy was thought to be linked to shame, which NSA-MHPs believed was related to upholding the reputation of themselves and their family. This was corroborated by female SASUs and SACMs, who stated that pressures from the community and family made it difficult to seek external help and disclose to an outsider, as the expectations of maintaining a 'perfect' image of themselves and their families was of utmost importance. One NSA-MHP stated that the difficulty for South-Asian women in accessing and committing to therapy was directly attributed to male relatives who possessed control over their actions. This NSA-MHP also identified religion as a controlling factor in the lack of freedom within South-Asian women. Interestingly, this view was not mentioned by any other

SA- or NSA-MHP. The concepts of shame and honour in relation to South-Asian women and the prevention of disclosure to outsiders have previously arisen in research (Zaidi, Couture-Carron & Maticka-Tyndale, 2016). The need to maintain a sense of honour or "*izzat*", while avoiding shame or "*sharam*", as they are referred to within the South Asian community, were noted as a barrier to help-seeking in a study conducted by Soni (2013). Understanding the emphasis placed on concepts such as *izzat* is crucial for therapists in order to understand some of the reasons which may prevent South Asians from accessing therapy or expressing themselves fully if they do choose to access it.

While an awareness of cultural norms is imperative when working with South Asian clients, issues arise when mental health is communicated to individuals who may not consider English as their first language. This comes from the lack of mental health terminology within languages prevailing across South Asia. This was noted by both interviewees from the South Asian community as well as therapists. This lack of mental health terminology suggests that ideas relating to mental health may not exist in those languages and may be considered 'alien' to those communities. This creates difficulty, especially for therapists who are required to work with clients via an interpreter, as the specific language that the therapist is communicating in is lost in translation. NSA-MHPs also shared their dissatisfaction in using an interpreter within therapy, as it was stated that they may input their own views and beliefs into therapy. This may depend on whether the interpreter has a background within psychotherapy; it could be the case that those who have a clinical background are less likely to impart their own beliefs due to training received. While there have been suggestions that non-English speaking South Asians receive therapy in their first language, the issue of an absence in mental health terminology still remains. Improving this situation will require an introduction and normalisation of mental health

terminology in South-Asian languages to be able to educate non-English speakers on the subject. A BME participant within the NSA-MHP group also recommended the use of describing mental health concepts in somatic form, as this was often the way in which they communicated and acknowledged their distress. While it was understood that differences in language created a barrier in communication within therapy, somatisation itself was not mentioned by SA-MHPs. Although there is the possibility that they did not experience somatisation within their sessions, it is likely that their shared cultural background – which may give them the ability to understand somatic expressions in the way they are intended - can cause a lack of acknowledgement due to such language being commonplace within the South-Asian community.

The topic of the South-Asian community attributing symptoms of mental health to supernatural problems was also common among most groups interviewed. It was believed that this attribution was a result of cultural stigma towards mental health issues, with families often finding it difficult to accept symptoms due to the negative impact it may have. For example, studies found that displaying culturally stigmatised behaviours could result in ostracisation from the wider community and jeopardise future prospects, such as marriage (Zaidi, Couture-Carron & Maticka-Tyndale, 2013). The difficulty in accepting mental health problems may link directly to collectivism within the South-Asian community. The importance of interdependence within the family structure relies on group members demonstrating strength. Because of this, exhibiting behaviours that are contrary to what is expected from within the community may be viewed as a risk to traditions and values that are of importance. This can result in ostracising those who may not show the characteristics needed to remain a part of the community, which can result in unacceptable behaviours and symptoms being attributed to external factors that are understood and accepted culturally.

There is also the possibility that stigma towards 'abnormal' behaviour prevents individuals from seeking an understanding towards it, with one participant from the South-Asian community stating that people are either seen as being mentally stable or insane, with no notion of mental health being on a spectrum.

The cultural beliefs held towards attributions of mental health leads individuals in this community to seek help through traditional means. This was mentioned by the SACM and NSA-MHP groups, as well as within previous research (Amin, Islam, Gilani, 2015). Although there was a reluctance in seeking external sources of help, it was found that members of the South-Asian community would access services in private, choosing not to share their decision with the wider community to prevent being labelled as 'crazy' or 'insane'. It was also found that services were accessed by those who reached crisis point, which may relate to the importance of being accepted and attempting to resolve issues in a manner that provides individuals and their families with a support network. However, it is also possible that members of the community are simply unaware of existing mental health services until crisis point is reached, at which point they may be referred by healthcare professionals. Although services may be sought, it is important to note that service users' progress may be dependent on the views and causal attributions held by the family, with a SA-MHP noting that cultural beliefs of the family can cause difficulty in establishing a therapeutic relationship with a client.

Both MHP groups stated that services were under-utilised by the South-Asian community, which was corroborated by Wilson & Deane (2012). On the occasions where South-Asian service users felt dissatisfied with the service received, sharing these experiences with the social group led to others not accessing similar services, resulting in a

further under-utilisation. In order to combat this, it was suggested that therapists should engage in community outreach, with one SA-MHP noting that displaying the 'human side' of mental health professionals and educating the community from within was imperative to improving access to therapies. The education of mental health within the South Asian community contributes towards clarifying mental health and illness, creating a greater likelihood for services to be accessed. This was observed within the interviewees from the community group. Those who had a higher level of mental health literacy had a more positive attitude towards mental health and help seeking. It was also more common for families to offer support and seek help rather than dismiss or minimise the issue if there was a greater understanding of mental health. This was corroborated by Tahani (2016) who found that exposure to psycho-education reduced negative perceptions towards individuals with mental illness.

In contrast, families with lower mental health literacy had a tendency to 'brush it under the carpet', as the lack of acknowledgement was thought to reduce its existence. This provides a valuable insight into the effects of mental health education on cultural norms and how the influence of culture can be diminished through increasing an understanding and awareness of mental health. This results in the influence of culture reducing, as well as creating advocates for mental wellbeing. All participants who belonged to the SASU group stated that their positive experiences of therapy had combatted the views they initially held, and its benefits were shared widely with others.

It is important to note that awareness of services may not reduce the apprehension of community members. Apprehension and anxiety towards services prior to accessing them was found to be common with all participants in the SASU group. There is a possibility that

these concerns stem from cultural attitudes towards seeking help but was also linked to being unaware of the process. All participants from the SASU group mentioned being hesitant with regards to accessing services as they feared they would be perceived in a negative light by those around them. Additionally, there was an expression of fear that this potential negativity towards themselves would extend to their families. In order to combat the apprehension and lack of disclosure, MHPs stated that emphasising confidentiality and providing a space of safety would often reassure SASUs and dispel any concerns they may have.

It was also mentioned that there were numerous barriers preventing access into therapy, which has been corroborated by McLean et al. (2003). The frustration towards GPs was prevalent among most groups. It was verbalised that there was a tendency for GPs to provide medication for mental health related issues instead of referring individuals to talking therapy. One of these examples arose in the NSA-MHP group, in which it is explained that GPs would attempt to wean patients off medicine for MHC such as depression without offering alternatives, such as talking therapy. This was found to result in negative experiences and dissatisfaction towards primary health care and was supported by Smith (2012) and Czyz et al. (2013).

Although most SASUs within this study found services to be culturally relevant for their needs, it is apparent that this is dependant on the therapist and the approaches they use within therapy. It was found that the way in which therapists from either group conducted therapy with SASUs was not based on their culture or ethnicity, but personal beliefs based on their experiences. Interestingly, NSA-MHPs who were aware of stereotypes and perceptions that they may hold towards the South-Asian community were more likely to

attempt understanding the culture to dispel any preconceptions that they may have. There was also some hesitancy in providing suggestions towards what could be done to make services more suitable for the South-Asian community, due to the awareness of not having a complete understanding of the culture or community. NSA-MHPs who were able to acknowledge their preconceptions also displayed a greater understanding towards the current level of services for the South-Asian community, believing it to be unsuitable. Similarly, in the SA-MHP group, preconceptions were able to be acknowledged and challenged by the therapist, showing that they were able to overcome any obstacles that they may bring into therapy.

In contrast, there was one NSA-MHP who held the belief that existing services were suitable for all and that members of the South-Asian community would have no difficulty in accessing them. The inability to recognise the numerous barriers that could prevent South-Asian individuals from accessing services was found to have an impact on the way therapy was delivered to SASUs; without recognising the need to gain cultural understanding or awareness. It was also reported that the inability to recognise stereotypes held towards service users based on their culture or faith could risk affecting the therapeutic alliance, as these preconceptions were unable to be diminished. This finding highlights the need for therapists to understand the preconceptions that they may bring into therapy, so they can develop their understanding and provide a service that does not discriminate based on their prejudices towards service users. This view has been supported by Bhui et al. (2012).

4.1 Limitations of the study

One of the challenges within this study was the difficulty of recruiting participants who identified as South-Asian service users. One of the factors that may have limited

participation in this study may have been the researcher's ethnicity. Participants within the service user group mentioned the lack of trust towards South-Asian therapists without having accessed them, as they applied the beliefs attributed to South-Asian community members on to professionals. Participants held the view that the cultural identity of the therapist would influence their behaviours, without acknowledging adherence to professional guidelines. As the researcher was of South-Asian origin, this lack of trust and fear of judgement may have also extended to her, with potential service user participants feeling as though their private matters may not be dealt with confidentially. The cultural emphasis on non-disclosure and keeping issues hidden from the community may have also resulted in this if they attached the identity of the researcher to her cultural background, being seen of as part of the community instead of someone who was simply conducting research. This may have also limited how open the service users who did participate in the study were willing to be. However, this cannot be objectively verified.

There was also no diversity in the ethnicity or gender of the service user group. This may be due to Pakistani's making up a larger proportion of South-Asians in the UK, although not larger than those from Indian backgrounds. The researcher's ethnicity may have been recognisable because of her name. This may have resulted in non-participation from South-Asian sub-groups, possibly worrying that sub-cultural differences may not be understood. The absence of males within the service user group may highlight feelings of discomfort in disclosing to a female of the same background. There was also a difference in the ratio between White European and BME mental health professional interviewees. One participant stated that all service users were treated the same in accordance to public health service guidelines. Holding the belief that existing mental health services are adequate for the entire population in the UK may have resulted in the lack of participation from some MHPs.

Interviews were conducted in English which may have prevented those who were not fluent from participating. The length of interviews also varied, which may have been the result of interview bias. Another limitation within this research was the small sample size of the SASU and SACM groups. While the data gathered allows for a rich understanding of views and experiences to be gained, the small sample size and lack of ethnic and religious diversity does not allow for an insight into the views and perceptions of the South-Asian community in England. It is important to note that the small sample size cannot be extended to the wider South-Asian population and therefore may not be suitable for exploring whether talking therapies are culturally relevant for British South-Asians across England.

Although snowball sampling offers the opportunity for research to extend to potential participants through word of mouth, one of the issues that come with utilising this approach is that it relies on interpersonal relationships and the participants' social group to share the characteristics or issues that are being explored. It is also possible that, with a very small participant group to begin with, potential participants gained may only be representative of a small portion of the entire population being studied.

4.2 Future research

Future research should aim to take a longitudinal ethnographic approach, building rapport over time with South-Asian service users in order to gain access to this hard to reach group (Glesne, 1989). Conducting interviews in the mother tongue of participants who may be unable to communicate in English would be beneficial, gaining an insight into a sub-group that may otherwise not participate. It would also be encouraged to explore how mental health is conceived within South-Asian communities where members do not speak English, identifying how mental health terminology can be introduced to this group and how this

may affect their understanding of it. Additionally, it would be useful to conduct research on the reasoning behind the mistrust towards therapists from the same background, evaluating the course of action that needs to be taken to remedy the situation. It would also be useful to explore the effects of therapists' beliefs regarding psychological approaches used within therapy. Lastly, it would be of interest to assess the level of cultural competence among MHPs.

4.3 Implications for therapists

In order to provide a therapeutic service that results in a positive experience for South-Asian service users, it is imperative that therapists acknowledge the importance of culture and the role of family within the South-Asian community. It is important to understand the difficulties that may lead to mistrust towards therapists and attempt to overcome this by accessing service users through community outreach; building rapport that includes some degree of disclosure. It would also be beneficial to provide a flexible service, understanding the needs of service users and recognising techniques that would be useful to their growth. Gaining an insight into the South-Asian culture should not be used to generalise service users, but to prepare for cultural issues and difficulties that may arise in therapy. To increase cultural awareness, it would be recommended to engage in cultural reading, communicating with BME colleagues and community or faith leaders, as well as being accepting of traditional sources of help, in order to gain an insight into how they help the community. These suggestions have been offered to increase the level of accessibility towards services and result in positive outcomes.

4.4 Recommendations for service providers

It would be highly beneficial for services to build community links with faith and community leaders, understanding the differences in how to reach different generations within the South Asian community and providing services in first-language in additional locations. It would also be useful to train mental health professionals on cultural awareness and understanding so they may offer services that are most beneficial to the service users'; including an emphasis on safety, comfort and confidentiality within sessions. Providing mental health worksheets in first-language would allow service users with limited English to be able to understand the benefits of therapy and increase engagement. Adapting Western models to therapy for the South-Asian community would also be helpful, allowing them to be able to disclose in a manner that is easiest for them, and learning to adopt somatic language to connect with service users. Investing in BME professionals would increase visibility for service users who may perceive services to be unapproachable. Provision of cultural or religious requirements, such as food that is suitable for their dietary requirements and prayer space, during community outreach would further increase accessibility to services, as would explaining the benefits of therapy in a manner that the community would understand. It would further benefit the community if services were to educate GPs on mental health and talking therapy, as well as advising them to refer potential patients.

4.5 Limitations to therapy

While therapy and existing services could be improved through the recommendations offered above, it is also important to note that without changes from existing service providers and therapists, talking therapy may remain under-utilised by the South-Asian community. This includes a lack of understanding towards individual and

cultural needs as well as the importance of actively seeking the community not being understood by services. There should also be an attempt to break down the barriers that cause members of this community to feel dissatisfied with services, such as the lengthy waiting time.

4.6 Conclusion

While there are services specifically catered towards BME groups, mental health professionals who understand the importance of culture in relation to the therapeutic process have taken action to adapt the services they offer in order to cater to the needs of their clients. This has led to greater engagement with mental health services and potentially creates advocates of those services. However, there is still more that needs to be done. Simply creating this service may not be enough, with the need for professionals to engage in community outreach to raise awareness of mental health in a holistic manner. While educating the community on mental health will increase engagement, adapting mental health vocabulary into native languages spoken by this community will greatly help normalise the presence of mental health within it. Through a combination of increasing cultural sensitivity, educating the community and adapting mental health vocabulary, the South-Asian community will be able to make the most out of the services available.

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Appendices

APPENDIX A. Contacted charities:

North-West	West Midlands	South-East and-West	East of England	London
Crewe and Nantwich Mental Health Sector Planning Forum	616 Community Centre	Wokingham and West Berkshire Mental Health Association	Reach Out	Ashiana – Sharon
Stockport and District MIND	Act Up for Mental Health	Berkshire Women's Aid	The Befriender	Asian Women's Resource Centre
Halton MIND	Birmingham LGBT Centre	Maidenhead Association for Mental Health	Bedfordshire Sexual Abuse Helpline	Henna Asian Women's Group
New Way Forward	Birmingham Mental Health and Community Resource Directory	People in Partnership	H.O.P.E (Hear Our Past Experiences)	Hopscotch Asian Women's Centre
Beacon Counselling	Brainstorm Community Arts and Mental Health	Richmond Fellowship	Carers MK	Newham Asian Women's Project
START in Salford	BTCV – Dudley Green Health Project	City Counselling Centre	Counselling Foundation	Southall Black Sisters
Arts for Recovery in the Community	RSVP	Men's Aid	Dunton Centre for Counseling and Psychotherapy	West Hampstead Women's Centre
Winsford Mind	Dudley Advocacy	Rethink Community Support Services	Bedford District Support Group for People with Eating Disorders	Solace Women's Aid
Macclesfield MIND	East Birmingham's Women's Project	Peoples Voices	Peterborough Fenland Mind	Newham Action Against DV
Sale Moor Community Partnership Limited	Full Potential Arts	Improving Mental Wellbeing Physical Activity Coordination Team (IMPACT)	Cambridgeshire Independent Advocacy Service	Nia Ending Violence
	Good as You (Gay/Lesbian Support Group)	Balanced MK	Advocacy Project	Refuge
	Hear Our Voice Kinmos Volunteer Group	Aylesbury Vale Advocates	Peterborough Empowerment Project	Rights of Women
	MIND Birmingham	Wycombe Mind	Voice Ability	Women & Girls Network
	Mind Community Services	Me, Myself, I	MHPF	Women's Resource Centre
	Moving On	MK Act	Hunts Mind	
	North Birmingham Advocacy	Bath Mind	The Cog-wheel Trust	
	Positive Mental	Advocacy and Befriending Service	Parkside Counselling Group	

	Health Group Rethink – Black and Ethnic Minority Carers Support Group Sparkhill Asian Women's Association User Voice Walsall Black Sisters Collective	Dhek Bhal Bangladesh Association Avon Counselling and Psychotherapy Service Humdard Asian Women Organisation Asian Health and Social Care Association Awaz Utaoh Bristol Crisis Service for Women Womankind – Bristol Women's Therapy Centre Sehatmand Aurat (Asian Women Health Project) Hartcliffe Health and Environment Action Group Changes – Mutual Help Group One in Eight The Wellspring Wellbeing Project Bristol MusicSpace Bristol Muslim Cultural Society Careforum Feed the Homeless Bristol Bristol Women's Voice	St Columba Group Therapy Centre Choices for Men Cambridge Manic Depression Fellowship Self-Help Group Cam-Mind (Cambridgeshire Mental Welfare Association) Lifecraft Gwydir Project (Turning Point) The Cambridge Clubhouse Hunts User Forum Mental Health Service Users Trust Cambridge Friend Peterborough Friend Oxmoor Wellbeing Link (O.W.L) Peterborough Empowerment Project	

		Black South West Network Khaas Bristol Bristol Bangladeshi Women's Organisation Bristol Pakistani Community Welfare Organisation Bristol Women's Voice Nilaari		

APPENDIX B. Information sheet (service user):

University of Bedfordshire

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Participant Information Sheet

The study
We are interested in learning about your experience(s) in having previously received talking therapy (or therapies) as a South Asian living in England.

Invitation Paragraph
You are being invited to take part in a research study. It is important to note that you should not take part if you are currently undergoing therapy, in psychiatric care or in a state of distress. You must be 18+ and have been out of therapy in the last six months. Please take time to read the following information carefully in order to understand why the research is being done and what it will involve. You are free to discuss it with others and welcome to ask us if anything isn't clear or if you would like more information.

Do I have to take part?
Your participation in this study is entirely your choice. If you do decide to participate, it would be on a voluntary basis. You will be given this information sheet and asked to sign a consent form. Although you may choose to take part, you have the right to withdraw at any point up until August 2017 without providing a reason.

What will happen to me if I take part?
You will take part in an audio-recorded interview with the primary researcher (Sidhra) regarding your experience(s) of receiving talking therapy (or therapies) in the past. It will roughly last 1-1.5 hours depending on the information you provide. The researcher will provide follow-up questions in response to the information you share to develop a discussion and gather an overall understanding of your individual experiences – there are no wrong answers. It is important to note that we will not be focusing on the reason you attended therapy unless you feel comfortable to elaborate on this. For example, if the

reason you attended was directly affected by the way you received therapy, you may wish to expand but you will not be forced to talk about anything that makes you uncomfortable. We are only focusing on the therapy you received and whether you feel your culture impacted this.

Will my taking part in this study be kept confidential?
Yes. Face to face semi-structured individual interviews will be conducted at a mutually agreed time in a quiet space at the University of Bedfordshire's Luton campus that will allow you to voice your experiences in a confidential and comfortable manner. If this is not suitable, phone and video-call interviews are also available. It will be audio-recorded on a password-protected Dictaphone for transcription purposes and kept on a password protected laptop that is only accessible to the primary researcher. Once transcription is complete, the audio-files will be permanently deleted. The written document containing your data will be numerically coded and you will never be referred to by your real name (pseudonyms will be used in the write-up stage). Therefore, it will not be possible to identify you in any way. Consent forms will be place in a locked storage facility only accessible by the primary researcher. The results of the study will be published in a peer-reviewed journal, but you will not be identified in any way. Data collected will be kept for a maximum of five years for future comparative research.

Please note that disclosure of harm to yourself or others will be reported to the DS.

Who is organising this research?
The research is organised by Sidhra Khalil, a post-graduate research student studying at the University of Bedfordshire under the supervision of Dr. Maja Jankowska. Contact details for both individuals can be found on the reverse side.

This copy is for you to keep. If you decide to participate, you will be given a copy of the signed consent form to keep.

Information sheet (community member):

University of Bedfordshire

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Participant Information Sheet

The study
We are interested in learning about your general perceptions of talking therapy as a member of the South Asian community in England. We are keen to understand your views, and whether you would consider accessing services.

Invitation Paragraph
You are being invited to take part in a research study. It is important to note that you should not take part if you are currently in a state of distress. You must be 18+. Please take time to read the following information carefully to understand why the research is being conducted and what it will involve. You are free to discuss it with others and welcome to ask us if anything is not clear or if you would like more information.

Do I have to take part?
Your participation in this study is entirely your choice. If you do decide to participate, it would be on a voluntary basis. You will be given this information sheet and asked to sign a consent and demographic form. Although you may choose to take part, you have the right to withdraw at any point up until August 2017 without providing a reason.

What will happen to me if I take part?
You will take part in an audio-recorded interview with Sidhra regarding your views of talking therapy as a member of the South Asian community. You will also be asked to think about your culture and its attitudes towards mental health and accessing services. The interview will last appropriately 1-1.5 hours depending on the information you provide. The researcher will provide follow-up questions in response to the information you share to develop a discussion and gather an overall understanding of your individual experiences – there are no wrong answers.

Will my taking part in this study be kept confidential?
Yes. Face to face semi-structured individual interviews will be conducted at a mutually agreed time in a quiet space at the University of Bedfordshire's Luton campus that will allow you to voice your experiences in a confidential and comfortable manner. Phone and video-call interviews are also available. It will be audio-recorded on a password-protected Dictaphone for transcription purposes and kept on a password protected laptop that is only accessible to the primary researcher. Once transcription is complete, the audio-files will be permanently deleted. The written document containing your data will be numerically coded and you will never be referred to by your real name (pseudonyms will be used in the write-up stage). Therefore, it will not be possible to identify you in any way. Consent forms will be place in a locked storage facility only accessible by the primary researcher. The results of the study will be published in a peer-reviewed journal, but you will not be identified in any way. Data collected will be kept for a maximum of five years for future comparative research.

Please note that disclosure of harm to yourself or others will be reported to the DS.

Who is organising this research?
The research is organised by Sidhra Khalil, a post-graduate research student studying at the University of Bedfordshire under the supervision of Dr. Maja Jankowska. Contact details for both individuals can be found on the reverse side.

This copy is for you to keep. If you decide to participate, you will be given a copy of the signed consent form to keep.

Information sheet (mental health professional):

University of Bedfordshire

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Participant Information Sheet

The study

We are interested in learning about your experience(s) as therapists or counsellors offering talking therapies to South Asian service users in England for mental health related issues. We are keen to understand how you feel the South Asian culture specifically can influence therapy sessions, as well as your thoughts on making cultural arrangements when helping this specific ethnic group.

Invitation Paragraph

You are being invited to take part in a research study. Please take your time when reading the following information to understand why the research is being conducted and what it will involve. You are free to discuss it with others and welcome to ask us if anything is not clear or if you would like more information.

Do I have to take part?

Your participation in this study is entirely your choice. If you do decide to participate, it would be on a voluntary basis. You will be given this information sheet and asked to sign a consent form. Although you may choose to take part, you have the right to withdraw at any point up until August 2017 without providing a reason.

What will happen to me if I take part?

You will take part in an audio-recorded semi-structured interview with the primary researcher (Sidhra) regarding your experience(s) of offering talking therapies to South Asian clientele in the past. It will approximately last 30 minutes to an hour depending on the amount of information you give. Prompts will be used to develop a discussion from the information you provide to understand your individual experiences.

Will my taking part in this study be kept confidential?

Yes. Face to face semi-structured individual interviews will be conducted at a mutually agreed time in a quiet space at the University of Bedfordshire's Luton campus that will allow you to voice your experiences in a confidential and comfortable manner. If this is unsuitable, phone and video-call options are also available. Interviews will be audio-recorded on a password protected Dictaphone for transcription purposes and kept on a password protected laptop that is only accessible to the primary researcher. Once transcription is complete, the audio-files will be permanently deleted. The written document containing your data will be numerically coded and you will never be referred to by your real name (pseudonyms will be used in the write-up stage). Therefore, it will not be possible to identify you in any way. The DS will only have access to numerically coded transcriptions and not the recordings. Consent forms will be place in a locked storage facility only accessible by the primary researcher. The results of the study will be published in a peer-reviewed journal, but you will not be identified in any way. Data collected will be kept for a maximum of five years for future comparative research.
Please note that disclosure of harm to yourself or others will be reported to the DS.

Who is organising this research?

The research is organised by Sidhra Khalil, a post-graduate research student studying at the University of Bedfordshire under the supervision of Dr. Maja Jankowska. Contact details for both individuals can be found on the reverse side.

This copy is for you to keep. If you decide to participate, you will be given a copy of the signed consent form to keep.

APPENDIX C: Consent form

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Consent Form

If you would like to participate in the study, please place an 'x' in the boxes below.

- I have read the research information sheet and had the opportunity to ask questions. ☐
- I understand that is project has been reviewed by and received ethical clearance through the University of Bedfordshire's Ethics Committee. ☐
- I understand that my participation is voluntary and that I am free to withdraw myself or my data until September 2017 without giving any reason and without any adverse consequences. ☐
- I understand who will have access to personal data I provide and what will happen to the data at the end of the project. ☐
- I will understand that my data will be stored securely on servers at the university of Bedfordshire; that it will be transferred where necessary using appropriate encryption algorithms; and that it will be stored securely in the United Kingdom according to the Data Protection Act (1998). ☐
- I understand that the findings from the study may be publicised in scientific journals, books, or other publications and anything published will not contain any information that could identify me. ☐
- I understand how to raise concerns or make a complaint. ☐
- I agree to take part in this study. ☐

Participant Pseudonym: _____

Participant Signature: _____

Date of Interview: _____

APPENDIX D. Interview schedule (service user):

- Introduction – what I aim to find out during the interview. Explain process. Reminder of withdrawal rights. Any questions? Ask for verbal consent before beginning.
- Could you give me a bit of background around your experience of receiving therapy for a mental health related issue?
    - When you first accessed therapy, how you accessed it, how it felt to access it.
- How do you feel mental health services cater to people from minority ethnic backgrounds?
    - What are your experiences regarding mental health services catered for people from minority ethnic backgrounds?
    - What were your personal experiences as a South Asian service user?
        - Can you think of any cultural challenges you faced throughout i) the referral process and ii) within therapy itself?
- What was the relationship between you and your therapist like?
    - How well do you feel the therapist understood your cultural background?
    - Has your therapist's cultural understanding influenced or affected the therapy process in any way? If so how? If not, please elaborate.
- Do you have any other experiences of receiving therapy?
    - If yes, how do your experiences differ?
- Having gone through therapy yourself, are there any (cultural) changes that therapists could make with South Asian service users to improve their experience?
    - What do you think could improve the cultural difference in a client-therapist relationship?
- Is there anything else you would like to say regarding your experiences as a South Asian service user?

[Thank and close]

Interview schedule (community member):

- Introduction – what I aim to find out during the interview. Explain process. Reminder of withdrawal rights. Any questions? Ask for verbal consent before beginning.
- Could you start off by giving me a bit of background around how you feel your culture feels about mental health and mental health services?
    - What are your personal thoughts?
    - Are you aware of any experiences in which mental health issues arose within your social or family circle?
        - In what ways were these dealt with?
- Are you aware of existing mental health services?
- What are your thoughts on existing mental health services in regard to the South Asian community?
    - Are you aware of any specific organisations that cater to this group?
        - What are your opinions on that?
        - Do you feel they are suitable?
        - Are they easily accessible?
    - What are your thoughts on accessing such a service yourself, if needed?
    - Is there anything that would prevent you from doing so?
    - What would make it easier?
- How do you think the South Asian culture might influence potential service users' attitudes to accessing and attending therapy?
- Can you think of any cultural challenges that may be faced by the South Asian community when trying to access therapy?
    - How about when they've accessed it and are receiving therapy?
    - Is there anything you feel non-south Asian therapists would find difficult to understand from a cultural perspective?
- What are your thoughts on therapists making cultural arrangements when treating South Asian service users, such as doing some research into issues that are regularly faced?
- Is there anything else you would like to mention that you haven't already? [Thank and close]

Interview schedule (mental health professional):

- Introduction – what I aim to find out during the interview. Explain process. Reminder of withdrawal rights. Any questions? Ask for verbal consent before beginning.

- Could you tell me about your experiences conducting therapy with South Asian Service Users?
    - Your first session with a South Asian client
    - Do you see any differences between South Asian service users and other clients/ patients?
    - Do you make any adjustments? If yes what? If not, why?

- What are your thoughts on existing mental health services for the South Asian community?
    - Do you feel like they are suitable?
    - Are they easily accessible?
    - Are you aware of any specific organisations that cater to this group?
        - What are your opinions on that?

- How do you feel mental health services cater to service users from BME backgrounds, specifically South Asians?
    - Can you think of any cultural challenges you have faced when offering therapy to South Asian clients?
    - Can you think of any cultural challenges your clients face when accessing therapy?
- What is the relationship between you and your SA clients like?
    - How does it differ to your relationship with non-BME clients?
    - How well do you understand the cultural differences South Asians may face?
    - What do you think can be done to improve the therapeutic relationship with South Asian service users?

- What are your thoughts on making cultural arrangements when treating South Asian service users?
    - Do you use any manuals or protocols? If not, why? If yes, do you feel like they need adjustment?

- How do you think the South Asian culture influences service users' attitudes and responses to receiving therapy?
    - What could be done to change this?
- Is there anything else you would like to add to the conversation today?

[Thank and close]

APPENDIX E. Demographic form (Service user and community member):

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Demographic Form

The following data will not be accessible to anyone apart from the primary researcher and will not be used individually within the write up of the study.

Pseudonym: _____

Age: _____

Ethnicity: _____

Non/Religious Affiliation: _____

Demographic form (Mental health professionals):

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Demographic Form

The following data will not be accessible to anyone apart from the primary researcher and will not be used individually within the write up of the study.

Pseudonym: _____

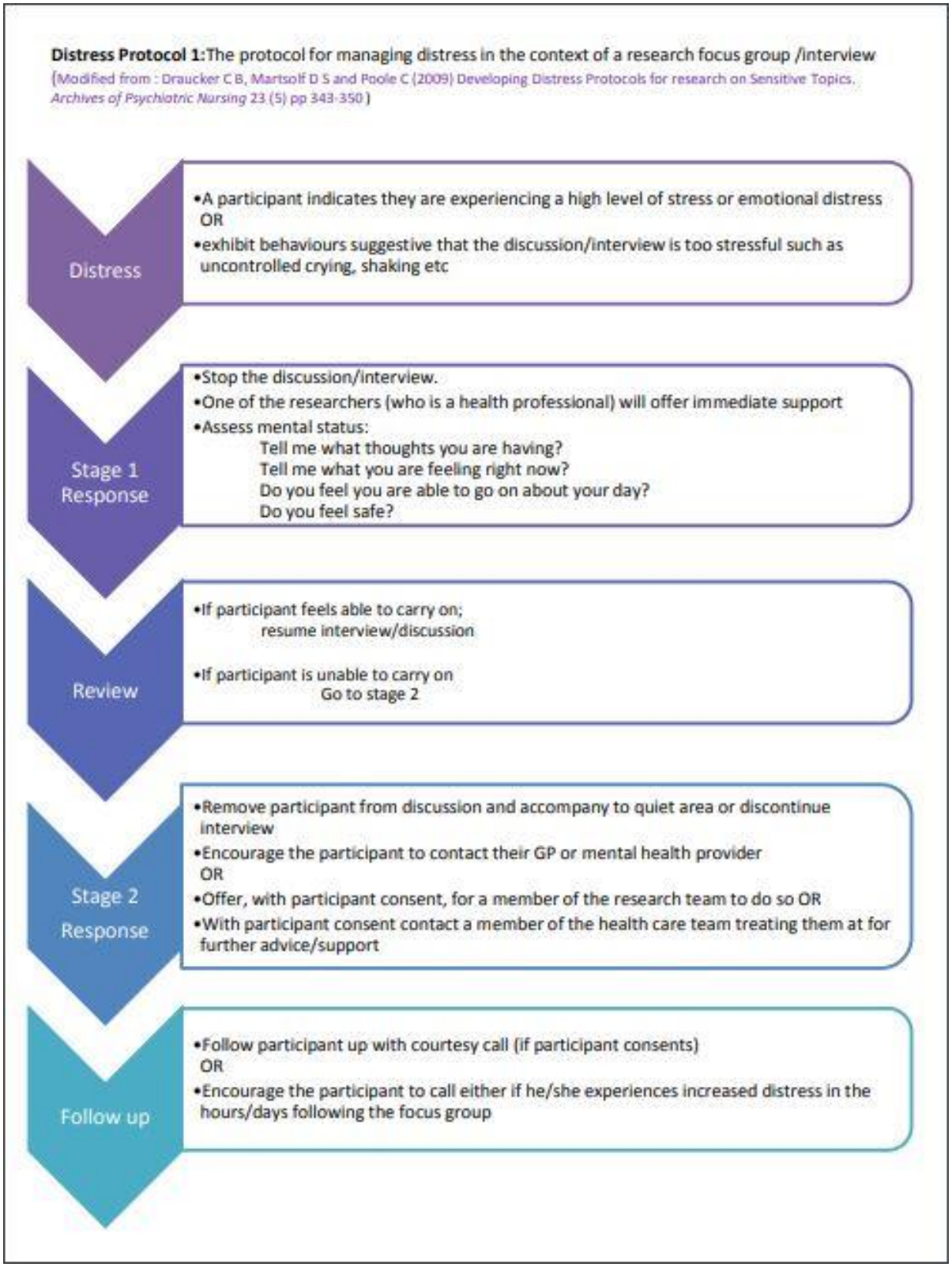
Age: _____

Ethnicity: _____

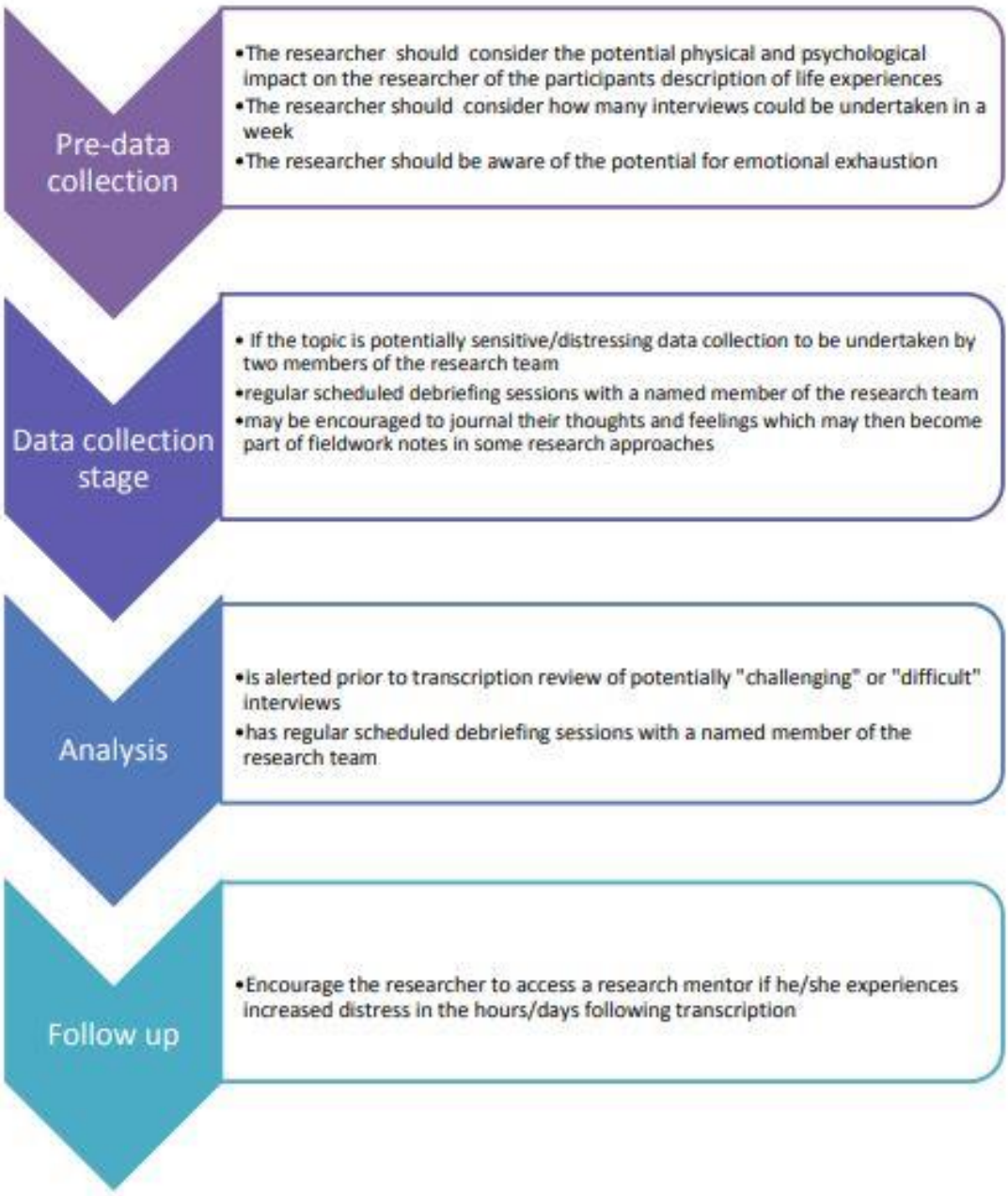
Non/Religious Affiliation: _____

Occupation: _____

APPENDIX F. Distress protocol

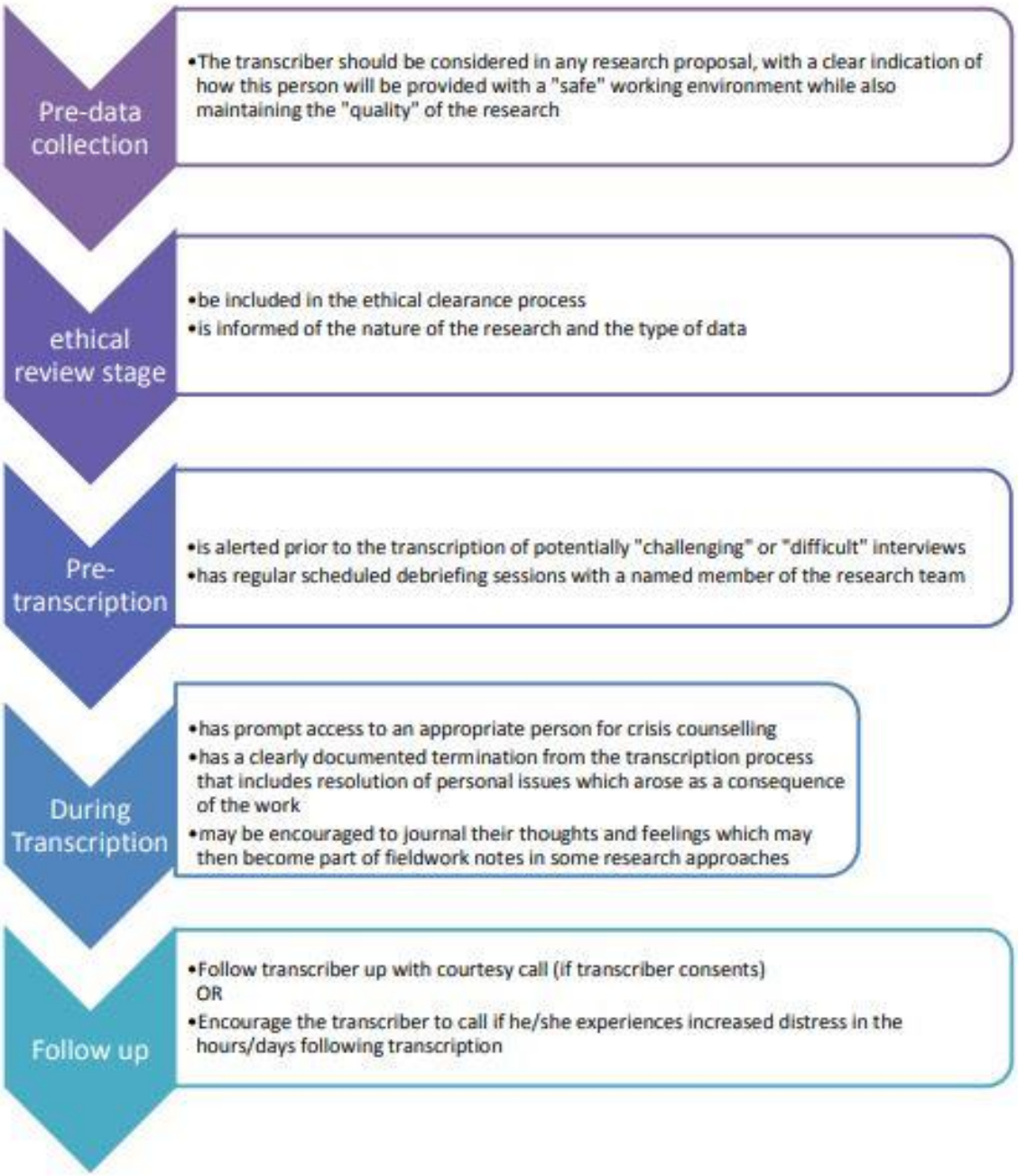


Distress Protocol 2: The protocol for managing distress in the context of a research focus group /interview management
McCosker,H Barnard, A Gerber, R (2001). Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All. Forum: Qualitative Social Research, 2(1)



Distress Protocol 3: The protocol for managing distress in the context of a research focus group /interview transcription

(Gregory, D Russell, C Phillips, L (1997). Beyond textual perfection: transcribers as vulnerable persons. Qualitative Health Research, 7(2), 294-300.)



APPENDIX G. Debrief form (service user):

University of Bedfordshire

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Debrief Form

Thank you very much for taking part in my research, the information you have provided has been very valuable. The study was conducted to investigate whether talking therapies are culturally relevant for the South Asian community in England. While research on culturally adapted therapies for minority ethnic groups has been conducted and found to be effective (Naeem et al, 2015), there is a lack of research that focuses solely on understanding the experiences of South Asian service users when therapeutic help is being or has been accessed. It is difficult to recruit South Asian participants within clinical research trials and just as difficult for South Asians to access mental health services for a mental health related issue, despite services existing (Rathod et al., 2010). Speaking about your experiences as a service user is very courageous and much appreciated. The data collected from your interview aims to understand your personal experience(s) of receiving talking therapy (or therapies) as a South Asian service user in England and whether the therapy you received was culturally relevant for your needs.

Should you feel the content of the interview has resulted in some personal difficulty, please remember to approach your supervisors. The following organisations are particularly helpful.

Samaritans of Luton, South Beds and Harpenden
33 Cardiff Road,
Luton, LU1 1PP
01582 720666
www.samaritans.org

Bedfordshire and Luton Mind: Luton Wellbeing Service
56 Dumfries Street
Luton, LU1 5BP
01582 757 625
www.bedsandlutonmind.org.uk

Bedfordshire Wellbeing Service (Improving Access to Psychological Therapies)
Gilbert Hitchcock House, Bedford Health Village,
21 Kimbolton Road,
Bedford, MK40 2AW
01234 880 400
http://www.bedfordshirewellbeingservice.nhs.uk/self-referral/

Debrief form (community member):

University of Bedfordshire

Luton, Bedfordshire
LU1 3JU, UK
Phone: 01234 400400
www.beds.ac.uk

Research Centre for Applied Psychology
School of Psychology
Faculty of Creative Arts, Technologies & Science

Primary Researcher: Sidhra Khalil
Email: sidhra.basharat@study.beds.ac.uk
Director of Studies (DS): Dr. Maja Jankowska
Email: maja.jankowska@beds.ac.uk

Debrief Form

Thank you once again for taking part in my research. The study was conducted to investigate whether talking therapies are culturally relevant for the South Asian community in England. While research on culturally adapted therapies for minority ethnic groups has been conducted (Naeem et al, 2015), there is a lack of research that focuses solely on understanding the experiences of South Asian service users when therapeutic help is being or has been accessed. It is difficult to recruit South Asian participants within clinical research trials and just as difficult for South Asians to access mental health services for a mental health related issue, even though these services exist (Rathod et al., 2010). This research aims to understand your personal experience of being a member of the South Asian community and how your culture views mental health and mental health services, which may impact how and when they are accessed. The information you have offered has been very valuable. Should you feel the content of the interview has resulted in some personal difficulty, the following organisations are particularly helpful.

Samaritans of Luton, South Beds and Harpenden
33 Cardiff Road,
Luton, LU1 1PP
01582 720666
www.samaritans.org

Bedfordshire and Luton Mind: Luton Wellbeing Service
56 Dumfries Street
Luton, LU1 5BP
01582 757 625
www.bedsandlutonmind.org.uk

Bedfordshire Wellbeing Service (Improving Access to Psychological Therapies)
Gilbert Hitchcock House, Bedford Health Village,
21 Kimbolton Road,
Bedford, MK40 2AW
01234 880 400
http://www.bedfordshirewellbeingservice.nhs.uk/self-referral/

Debrief form (mental health professional):

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Debrief Form

The study was conducted to investigate whether talking therapies are culturally relevant for the South Asian community in England. While research on culturally adapted therapies for minority ethnic groups has been conducted (Naeem et al, 2015), there is a lack of research that focuses solely on understanding the experiences of South Asian service users when therapeutic help is being or has been accessed. It is difficult to recruit South Asian participants within clinical research trials and just as difficult for South Asians to access mental health services for a mental health related issue, even though these services exist (Rathod et al., 2010). This research aims to understand your personal experience of offering talking therapy to clients of South Asian origin, your views towards existing mental health services and opinions on cultural adjustments within therapy for minority ethnic groups.

Should you feel the content of the interview has resulted in some personal difficulty, please remember to approach your supervisors. The following organisations are particularly helpful.

Samaritans of Luton, South Beds and Harpenden
33 Cardiff Road,
Luton, LU1 1PP
01582 720666
www.samaritans.org

Bedfordshire and Luton Mind: Luton Wellbeing Service
56 Dumfries Street
Luton, LU1 5BP
01582 757 625
www.bedsandlutonmind.org.uk

Bedfordshire Wellbeing Service (Improving Access to Psychological Therapies)
Gilbert Hitchcock House, Bedford Health Village,
21 Kimbolton Road,
Bedford, MK40 2AW
01234 880 400
http://www.bedfordshirewellbeingservice.nhs.uk/self-referral/

APPENDIX H. Transcript (service user excerpt):

Interviewer: Okay, so if you're okay to get started, I'm just going to tell you a bit about what I aim to find out throughout the interview. Erm, so, as you know, I'm looking at the perceptions of mental health and mental health services from the perspective of South Asians who have accessed therapies, and I'm also looking at the viewpoints of mental health professionals, so anyone from therapists, counsellors, assistant psychologists, et cetera. I do need to remind you about your withdrawal rights, so if you'd like to stop at any point, it's completely fine, just let me know. Throughout this interview, I'm just going to ask you some questions and depending on what you tell me, if I find something interesting, I'll just ask you to elaborate on it. And as you know, I am recording this for transcription purposes, so could I just gain your verbal consent before we begin?

SASU2: Yeah, that's fine to record, yeah.

Int: That's fine, that's great. So, could you just start off by giving me a bit of background around your experience of mental health and mental health services?

SASU2: Erm, yeah, I've accessed therapy a couple of times. Most recently, I'd been referred by my college and it was part of the erm, [organisation], erm, and then African charity therapy group, yeah. Really good, yeah.

Int: Brilliant, okay. And how was it when you first accessed therapy?

SASU2: Erm, I was a bit nervous, because I've never had it before. Erm, I've had counselling before but not in this setting. Erm, but, erm, once I was there and stuff, you- they made you feel quite welcome and stuff, and erm, when I went in, they'd ask if you wanted a drink and quite welcoming because I think they could probably tell that I was a bit nervous. Erm, and yeah, they were quite welcoming and erm, they told me it was normal, a lot of people go through it, erm, and stuff like that.

Int: Okay, and how did you feel accessing talking therapies?

SASU2: Erm, in the beginning, erm, I was a bit kind of... apprehensive about it, because, I don't know, I... it was just a bit weird going to it and stuff because erm, I don't know, I think I just felt a bit weird going into it and once I'd actually settled in and got to know my therapist, erm, I began to feel more comfortable and stuff. So, I felt like I could actually talk to them and speak about stuff that was on my mind whereas before that, I didn't really feel like I could speak to anyone about what was going on. Now that I've gotten to know my therapist and I've had like, quite a few sessions with her, so I'd say within the first few sessions, I felt quite comfortable with her because she was quite, you know, welcoming and open and, yeah.

Transcript (community member excerpt):

Interviewer: Okay. Why do you think, erm, when you said that mental health wasn't a valid concept within the SA community - why do you think that is?

SACM4: I think firstly it's, erm, that they, there's not really a recognition that mentally, you can be *unhealthy*. I think there's a- it's very black and white. So, it's either considered that you're mentally healthy or you're insane. And there's no real grey area in between those. Erm, the term used is, erm, saying, you know, "They're mad", as in they're not in- they're not in control of their senses and rather than being helped or being treated, generally it's seen as they need to be shunned. Erm, or you don't speak about it because it's kind of embarrassing to have someone who, in the family, is mad. But when it comes to actual mental health, there's not really anyone talking about it. So, I don't see how that concept can exist. And I think one of the distinct things about MH, especially within the South-Asian community or at least the community that I*'ve* been brought up in is that there's not *really* any- any language relating to mental illness. Not in the same way that there's language relating to physical illness. So, things like, having a cold. In English, you say you have a cold. In my language, or my South Asian language, you just say you have '*sardi'.* And it means the same thing and that- the words may be different but when someone says *'sardi'* and when someone says they have a cold, they're talking about exactly the same thing. They're talking about those symptoms where you have a headache, congestion, maybe a cough, sore throat - those kind of things. But when it comes to mental health, things like depression, things like anxiety, things like, erm, states of stress, there's not really a word for it. Not that I'm aware of anyway. So, when people don't have the language to be able to talk about their condition, you kind of wonder whether or not it's understood to even exist.

Int: Okay. Okay. If we just speak about the language for a moment, why, why do you think that language doesn't exist for words sort of translating into, erm, the languages that are spoken within the SA culture?

SACM4: I think it may have something to do with the fact that most people have been more concerned with their physical wellbeing that they haven't really had a chance to think about their mental wellbeing. A lot of the people in the South-Asian countries typically-until recent history-have been quite poor. So, their focus has always been on physical health because they can see it, they can do something about it easily. So, they've always been on the lookout for *physical* conditions. Mental health conditions- *sigh*, I don't think- when it comes to survival, people just didn't see it as, really *as* important, because *sigh* your mental state can be bad, but you can still be alive and when you're living in poor conditions, being alive is the most important thing. So, I think there may be something relating to that as to why it hasn't been the focus. I mean even in Western societies where you have, like, richer communities, it's really only become a focus in recent years, or in recent history and that has to do with some cultural changes but also possibly to do with the fact although there are numerous physical conditions, we've found a lot of ways to remedy those or at least erm, slow them down, and you can start shifting your focus to mental conditions and how that affects people. So maybe that has something to do with it.

Transcript (mental health professional excerpt):

Interviewer: Okay. And have you seen any differences between South-Asian service users and erm, for example, other patients from non-BME groups?

NSA-MHP2: Absolutely. Yeah. Erm, I don't wanna generalise, but I actually see a difference, at least with the ones that I have worked with. Erm, the non-Asians, erm, when they didn't disclose, it was more to do with sort of, like, erm, the actual issue, rather than erm, 'Oh, I don't know if it's okay to tell this stuff about my family.' You know, that was slight, very subtle difference, but I could pick that up.

Int: Okay.

NSA-MHP2: So, because, what I mean is, with er, non-Asian ones, erm, the moment they start to become erm, aware of the issue, what we were working through, then they become more say, you can tell that it's just because of their actual issue - mental issue that they were going through and not so much culture, you know what I mean? Whereas, erm, even with like, my first female client, even six, eight weeks in, when we sort of covered, you know, self-esteem issues and all that kind of stuff and gone through that, there was still areas of being afraid to talk about like, even sexual things, or you know, which was very, very personal, I felt. Yeah.

Int: Okay. And did you make any cultural adjustments within therapy?

NSA-MHP2: Erm, yes, I knew I needed to. Erm, because it's, well, part of my training anyway, that you just erm, while you treat everybody as an individual and a human being, you know, value them for being an individual. Erm, you still have to bear in mind, you know, cultural erm, ideas and beliefs, and that is what's okay for *them*. So, it didn't interfere so much with therapy because I understood that part, but just tried to be empathic enough that they feel *safe* enough to talk about that stuff, but I did understand that.

Int: Yeah, okay. And what are your thoughts on existing mental health services for the South Asian community?

NSA-MHP2: Well, interesting, because I don't think that there is enough available, erm, that targets erm, this population. Erm, what I've seen in my own practice is a lot seem to be sort of hidden because it's almost like stigma within the culture, you know. That, “Look, okay, you are a wife and you need to be told what to do and you have no voice”, kind of thing, and “You better shut up because this is how it is”, kind of attitude. Erm, and so because of that, I feel like the general public who are supposed to be looking at these things don't really put enough emphasis into really seeing how hurt these women are, especially. Like, so we see that with erm, women come in, you know, domestic violence and stuff like that, who will suffer for a very long time because they don't really wanna cause shame on the family which is so close-knit, so they bottle up all that stuff inside, you know.

APPENDIX I. Initial thematic categories (service user group example):

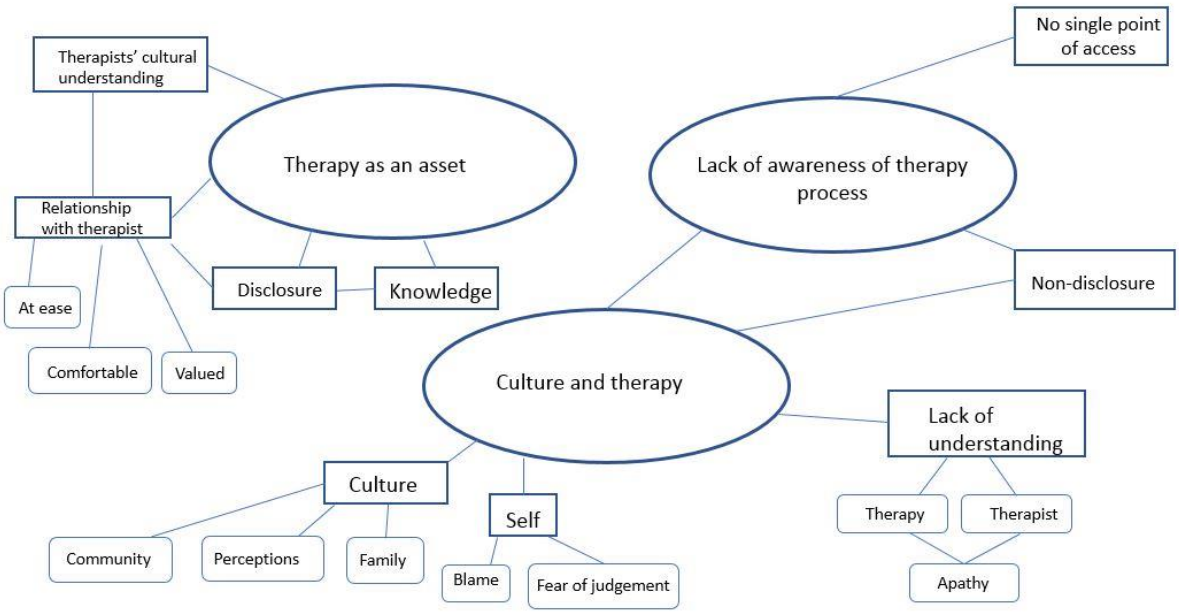
Organising codes:

	A	B
1	Participant	Codes
2	SASU	Initially apprehensive about access
3	SASU	Disclosing for the first time
4	SASU	Put at ease during assessment
5	SASU	Unawareness of therapist causing anxiety
6	SASU	Thoughts of pulling out of initial session
7	SASU	Initial access daunting
8	SASU	Not knowing what to expect when accessing
9	SASU	Wondering whether therapist will understand
10	SASU	Fear about first session
11	SASU	Therapy recommended at assessment
12	SASU	Number of sessions provided according to disclosure
13	SASU	Self-referred to therapy
14	SASU	Organisation recommending therapy at assessment
15	SASU	Apprehensive disclosing private matters
16	SASU	Therapy benefitting service user
17	SASU	Apprehension towards disclosure stemming from marriage
18	SASU	Difficulty disclosing to stranger after years of silence
19	SASU	No previous disclosure before accessing MHS
20	SASU	Daunting accessing MHS with no previous disclosure
21	SASU	Relief upon meeting therapist
22	SASU	24 sessions offered
23	SASU	Therapist understanding service user
24	SASU	Therapist empathising despite ethnic difference
25	SASU	Therapists understanding having positive effect

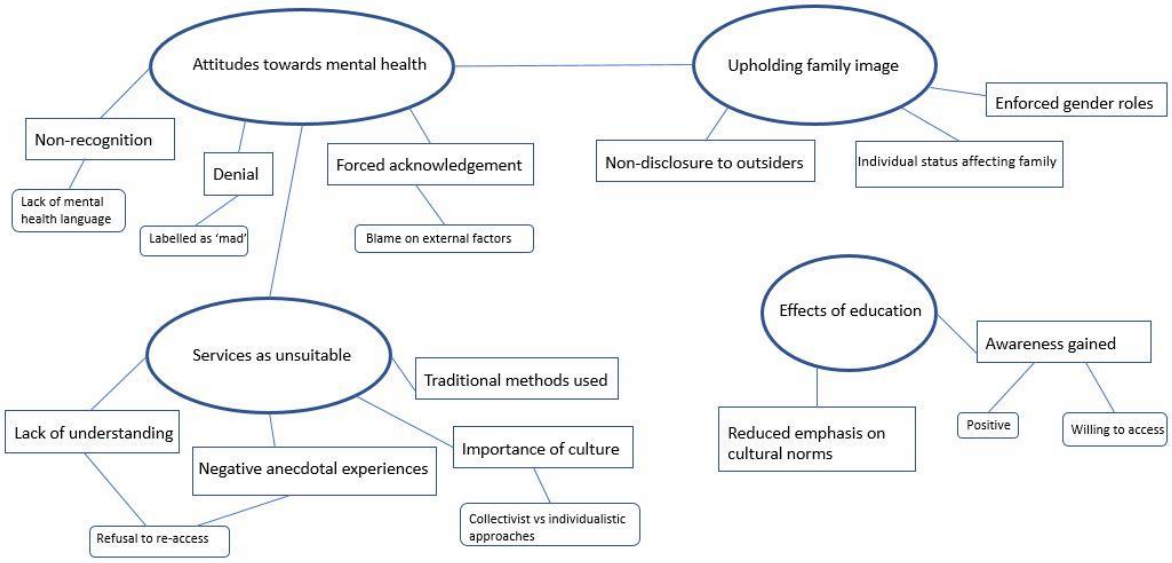
Placing codes into initial categories:

	A	B
1	Feeling towards access	Feeling once accessed
2	Initially apprehensive about access	Put at ease during assessment
3	Unawareness of therapist causing anxiety	Relief upon meeting therapist
4	Thoughts of pulling out of initial session	Feeling understood and valued by therapist
5	Initial access daunting	SU more to therapist as means of income
6	Not knowing what to expect when accessing	Therapist showing genuine care
7	Wondering whether therapist will understand	Helping SU through understanding
8	Fear about first session	Initially weird attending therapy
9	Apprehension towards disclosure stemming from marriage	SU feeling weird initially attending therapy
10	Nervous about accessing therapy	Feeling comfortable once settled into therapy
11	Initially apprehensive about accessing	Realising accessing therapy is normal
12	SU uncomfortable accessing therapy due to community	Positive decision made by SU to access MHS
13	Questioning whether accessing therapy is weird	SU realising that issues need to be spoken about
14	Questioning whether it is normal to have issues	SU thinking issues will go by themselves if not for therapy
15	Questioning need to access therapy	Therapy helpful after a few weeks of attendance
16	Cultural MH views making SU apprehensive to access	Accessing therapy was good
17	Initial worries due to cultural views	Perceptions towards therapy changed once accessed
18	Wondering if accessing therapies is overreacting	Benefits of speaking to stranger realised after a few weeks
19	Thinking access is overreacting	Importance of therapists acknowledged once service accessed
20	SU apprehensive towards starting sessions	SU not understanding benefits prior to access
21	SU initially apprehensive about access	Awkward talking while therapist is listening
22	SU questioning mother suggesting therapy	Weird accessing therapy
23	SU unable to see how speaking to stranger would be beneficial	Accessing therapy is normal
24	Fear of judgement from stranger	Personal perceptions of therapy changing once accessed
25	Therapy initially thought of as unhelpful	
26	Accessing therapy weird for SU	
27	SU holding similar perceptions of access to MHS	
28	Initially feeling MHPS would judge	

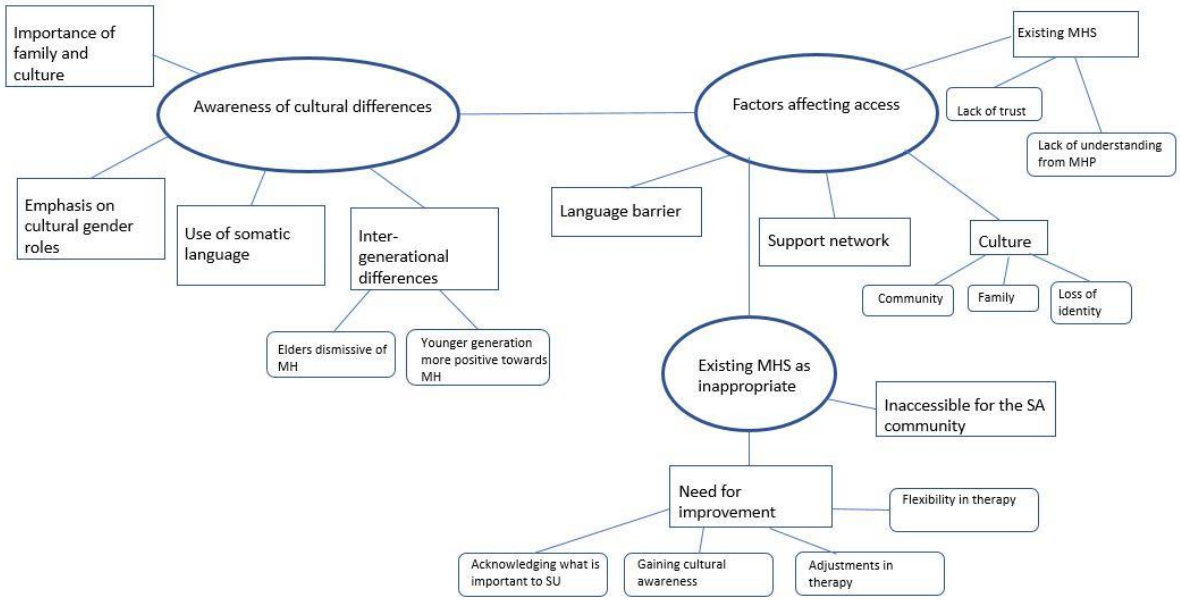
APPENDIX J. Initial thematic map (service users)



Initial thematic map (community members):



Initial thematic map (mental health professionals):

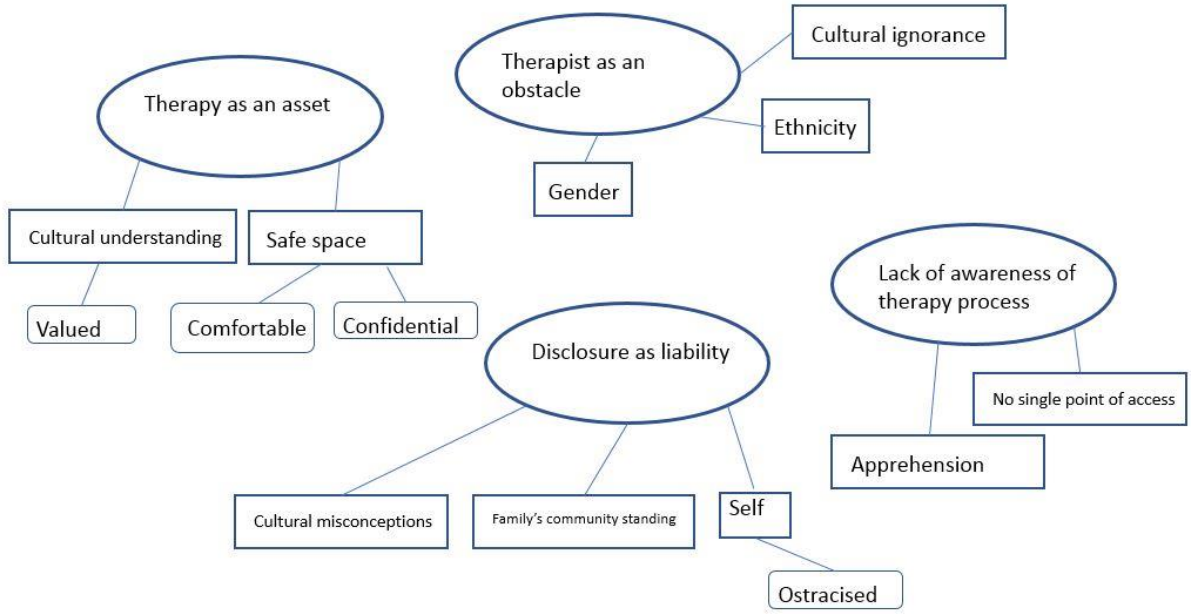


APPENDIX K. Final categories (service user group example):

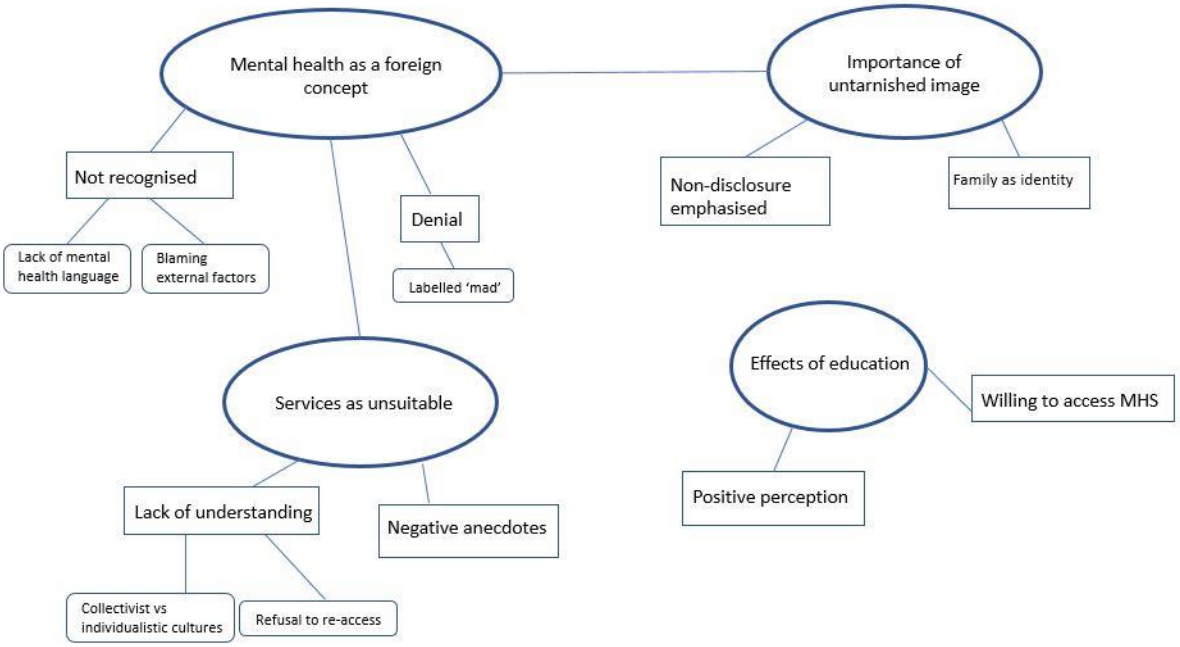
	A	B	C	D
1		ACCESS		
2	Access	Feeling towards access	Feeling once accessed	Avenues to access
3	**First:**	**Apprehensive:**	**Initial:**	**Self-referral:**
4	First experience of accessing therapy	Initially apprehensive about access	Initially weird attending thera	Self-referred to therapy
5	No previous experience of accessing therapy	Initially apprehensive about accessing	Perceptions towards therapy	**College:**
6	**Previous:**	SU uncomfortable accessing therapy due to community	SU not understanding benefi	Recent access referred through college
7	Previous access to therapy	Questioning whether accessing therapy is weird	Therapy initially thought of a	Drop-in therapy attended before referral to current therapy
8	Previous exp of therapy in different setting	Questioning whether it is normal to have issues	Awkward talking while therap	SU attending drop-in counselling
9		Questioning need to access therapy	Weird accessing therapy	Recommendation for structured therapy post assessment
10		Cultural MH views making SU apprehensive to access	SU feeling weird initially atte	Accessing therapist through college
11		Wondering if accessing therapies is overreacting	**Ease:**	Waiting list at college not long
12		Thinking access is overreacting	Put at ease during assessmer	**Private:**
13		SU apprehensive towards starting sessions	Relief upon meeting therapis	Mother deciding to take private route
14		SU initially apprehensive about access	**Valued:**	Mother referring child to private TT
15		SU questioning mother suggesting therapy	Feeling understood and valu	**Work:**
16		SU unable to see how speaking to stranger would be beneficial	SU more to therapist as mear	Option to access therapy through work
17		Accessing therapy weird for SU	**Comfortable:**	Employees encouraged to access therapy through work
18		**Anxious**	Feeling comfortable once set	Taking option of therapy through work
19		Unawareness of therapist causing anxiety	Realising accessing therapy i	**GP Access:**
20		Thoughts of pulling out of initial session	Accessing therapy is normal	GP accessed for MH symptoms
21		Not knowing what to expect when accessing	**Beneficial:**	GP accessed for referral to TT
22		Wondering whether therapist will understand	Therapy helpful after a few w	GP aware of MHS with long waiting list
23		Nervous about accessing therapy	Accessing therapy was gooc	**Difficulties:**
24		Initial worries due to cultural views	Benefits of speaking to strar	SU:
25		Initially feeling MHPS would judge	Importance of therapists ack	Unsure of MHS available
26		**Daunting**	Personal perceptions of ther	MHS for Asian community not publicised
27		Initial access daunting		No publicity of SA MHS seen
28		**Scared**		Unaware of service unless referred
29		Fear about first session		Not asking about services if unaware of availability
30		Fear of judgement from stranger		Thought of access TT not crossing SU's mind
31				Not thinking of accessing MHS when incident disclosed
32				Unable to wait on waiting list due to level of difficulty
33				Private therapy expensive
34				Having to pay €30/session for private TT
35				GP:
36				GP prescribing medicine for MHI
37				GP offered nothing more than medication
38				No referral made by GP

	H	I	J
1			DISCLOSURE
2		Discourage disclosure	
3	**CULTURE:**	**INDIVIDUAL:**	**THERAPIST:**
4	Cultural norms preventing disclosure	**Self-blame:**	**Lack of understanding:**
5	Prevention of disclosure within culture	Self-blame preventing disclo	Lack of cult understanding causing barriers of disclosure
6	Disclosure to stranger not normal within culture	**Fear of judgement:**	SU unable to open up to college therapist
7	Non-disclosure to outsider becoming a norm	Fear of judgment preventing	College therapist not understanding disclosure
8	Not allowed to disclose struggles	Feeling of being judged for	Not easy to disclose to college therapist
9	MHI's brushed under carpet within culture	Feeling of cultural judgemen	Different ethnic backgrounds causing lack of cult understanding by therapist
10	Cultural views making SU question self	Talking about family with the	Challenging to be open and honest in therapy
11	MHI blamed on external factors	Fear of blame and judgment	**Gender and ethnicity:**
12	**Community:**	Feeling of culture being weir	White British background of therapist
13	Being looked down on preventing access	Community blame women fo	Male therapist having white ethnic background
14	Society looking down on people	Worry of how service user w	Therapists ethnic background remaining same as previous therapists: white
15	Feeling of being unheard within society	**Neutral expectation:**	Gender:
16	People within community not focusing on MH	SU not shocked at therapist	SU finding disclosure to male weird
17	People not understanding benefits of therapy	Awareness of therapist's lev	Unable to open up to male therapist
18	**Cultural perceptions:**	Awareness of different level	Unable to open up when probed
19	Cultural perceptions of MHI/S making access uncomfortable for SU	Culturally unaware unless cul	Putting up a barrier in therapy
20	Cult perspective of mental health not being important	Therapist unable to understa	Difficult opening up to therapist due to gender
21	Causes of MH shouldn't affect ind		Difficulty disclosing due to gender differences
22	Cultural view of individual getting past situations that affect them		Unable to elaborate within therapy
23	Cultural perception of MHI as taboo		Cultural and gender differences making disclosure weird
24	Mental health being synonymous to 'crazy' within culture		Ethnicity:
25	MHI having negative label of being 'crazy'		Fear of judgment from same ethnic therapist
26	Cultural perceptions of questioning need to access		Feeling of same-ethnic therapist being passive towards issues
27	Perception of being 'crazy' if MHS accessed		Judgment from people of same culture
28	Difficulty accessing services despite awareness		MHP with same culture displaying judgment
29	Cultural mannerisms affecting access to MHS		Assumption of SA therapist holding similar views to SA laypeople
30	**Family:**		Idea of judgment from same-ethnic therapist
31	Non-disclosure:		Taking longer to open up and trust same-ethnic therapist
32	Not disclosing personal issues due to upbringing		SU wouldn't open up to SA therapist
33	Disclosure to family rather than outsiders		Assuming Asian MHP would be judgemental
34	Inability to disclose freely with family member		Judgement potentially becoming barrier to access
35	Emphasis of non-disclosure to outsiders throughout upbringing		Feeling of culture being abnormal to white MHP's
36	Issues kept within family in culture		Fear of judgment from white MHP's due to cultural differences
37	Image:		Fear of judgement from inds sharing background
38	Image of family perfection preventing disclosure		

APPENDIX L. Final thematic map (service users):



Final thematic map (community members):



Final thematic map (mental health professionals):